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colorado medicine

January, 1981

Volume 78, Number 1

COLO
MED
SOC

SPECIFICATIONS:

STANDARDS OF PRACTICE
LEGISLATIVE INVOLVEMENT
MEMBER SUPPORT
MEMBER SERVICES
COST EFFICIENCY

ENTROPY - HOW MUCH?

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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North Carolina 27709



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THE COVER

This month is representative of all of the resolutions made during 1980 for accomplishments planned or hoped for during the coming year. The cover is representative of more than that: Colorado Medical Society ... a blueprint for the perpetuation and improvement of private medical practice ... and your role as an individual physician member in building and protecting this structure. CMS does have a master plan, but no plan is effective without all of its component parts. YOU must be an active part in the plan.

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president's letter

How much time, effort and money do we devote to complying with regulation? How will these change under a new administration, a more conservative congress, etc.? Specific answers to these and similar questions are either difficult or impossible to find, but the following food for thought commentary was provided, at my request, by a CMS member physician who serves as hospital DMA and who is affectionately known to his constituency as "The Disneyland Correspondent."



My personal belief is that the costs of our health system will become so unacceptable in the near future that we will feel more greatly the "Entropy Index" alluded to herein. CMS and all organized medicine need to address the cost and regulation issues now—if you are moved to action or interest or thought, speak to your medical society!

At the recently concluded Mid-winter meeting of the American Medical Association, one of the prime issues of concern was that of federal involvement in physician peer review. Delegates voted that the AMA House of Delegates adopt a position amending AMA's policy concerning federal PSRO and health planning laws. As amended, the policy is "to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government-directed peer review programs, including PSRO." The idea that the PSRO is a quality review program has been lost in the federal book of guidelines and, as one physician put it, "in some cases has led to the rationing of health care."

I urge each of you to think of these matters as you read and ingest the "Entropy Index" printed on the following pages. Cost of compliance can well become one of the prime factors in determining the acceptability of our health care system in the very near future!

standards of practice

STANDARDS OF PRACTICE

There are three state-level bodies which can affect medical practice a great deal. One is the tax man. The two legitimate bodies are the Board of Medical Examiners and the Department of Regulatory Agencies. This column will explore the latter two.

Board of Medical Examiners Oversees Practice

The board is the state licensing body for the practice of medicine. Besides licensure, the board's major duties include investigation of unprofessional conduct, enforcement of provisions prohibiting the practice of medicine to unlicensed people, and oversight of continuing medical education. The board also oversees the practice of podiatry and child health associates.

By law, the board is composed of seven M.D.'s, two D.O.'s and two members from the public at large. The governor makes appointments to the board after giving due consideration to recommendations submitted by the "Colorado State Medical Society" and the Colorado Osteopathic Association. Board members are appointed to six-year terms. The current board chairman is Mr. Mike Vitek, a hospital administrator from Delta.

For purposes of discipline, the board is divided into two panels—inquiry and hearings. The inquiry panel investigates complaints and may dispose of them if it finds that the complaint is meritless or that there is no cause for further action. If the inquiry panel decides that more formal charges against a physician are warranted, it requests the Colorado attorney general to prepare and file formal charges. These are then heard by the hearings panel. Physicians who disagree with findings or actions of the hearings panel may request review by the Colorado court of appeals.

Department of Regulatory Agencies Plays Supervisory Role

The Department provides general administrative supervision for a wide range of state agencies. One of the Department's subsidiary branches encompasses the health professions licensing boards, including the Board of Medical Examiners.

The Board of Medical Examiners is legally autonomous as far as policy making, but it does rely on the Department for staffing and suggestions as to policy.

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CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

FEBRUARY 1981

2nd-6th

7TH ANNUAL ADVANCED WINTER WORKSHOP: TREATMENT AND REHABILITATION OF THE ALCOHOLIC. Contact: Gary C. Forrest, Ed.D., 3313 W. Carefree Circle, Colorado Springs, CO 80917. 597-5959. (25 prescribed hours of AAFP credit).

2nd-6th

5TH ANNUAL BIG SKY RADIOLOGY CONFERENCE. Big Sky, Montana. Contact: Phyllis Sherburne, Department of Educational Services, Columbus Hospital, Great Falls, MT 59403. (406) 727-3333. (20 hours of AMA Category 1 credit).

2nd, 9th, 16th, 23rd

PROBLEMS IN EGO DEVELOPMENT. Boulder Psychiatric Institute. Contact: Community Relations Coordinator, Boulder Psychiatric Institute, 4390 Baseline Road, Boulder. 447-2902. (AMA Category 1 credit).

5th

NEUROPSYCHIATRIC GRAND ROUNDS. Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

7th-14th

3RD ANNUAL VAIL EMERGENCY MEDICINE/CRITICAL CARE CONFERENCE. The Mark Resort, Vail. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

7th-14th

2ND ANNUAL VAIL GENERAL DENTISTRY CONFERENCE. Lion Square Lodge, Vail. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

8th-13th

WINTER SKIN SEMINAR. Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

8th-14th

NEW APPROACHES—INTERNAL MEDICINE. Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

9th

COMMON PROBLEMS IN PEDIATRIC PRACTICE. Burlington. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80202. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

9th-11th

15TH ANNUAL ASPEN CONFERENCE ON THE NEWBORN. Aspen. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947.

9th-13th

2ND ANNUAL CONFERENCE ON PROBLEMS IN GASTROENTEROLOGY: A CLINICAL AND PATHOLOGICAL APPROACH. Keystone, CO. Contact: Maxine Topping, American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104.

11th-14th

20TH ANNUAL JOHN R. DURRANCE MID-WINTER CHEST CONFERENCE. Aspen. Contact: Tony Marostica, American Lung Association of Colorado, 1600 Race Street, Denver, CO 80206. 388-4327. (10 hours of AMA Category 1 credit).

13th

MAXILLOFACIAL SURGERY. Estes Park. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

14th-21st

3RD ANNUAL PRACTICAL COUNSELING TECHNIQUE WORKSHOP FOR THE PRIMARY PHYSICIAN. Lion Square Lodge, Vail. Contact: John C. Faul, M.D., 5290 E. Yale Circle, Suite 200, Denver 80222. 758-5839. (34 prescribed hours of AAFP credit).

14th-21st

RECENT ADVANCES IN CARDIOLOGY FOR THE PRIMARY CARE PHYSICIAN & CARDIOLOGIST. Thunderhead Inn, Steamboat Springs. Contact: John Cogar, M.D., 550 South Beretania Street, Honolulu, Hawaii 96813. (20 prescribed hours of AAFP credit).

14th-21st

7TH ANNUAL VAIL OB/GYN CONFERENCE. The Mark Resort, Vail. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

CME Calendar Update

JANUARY 19, 1981

ORAL HYPOGLYCEMIC AGENTS

Salida, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

(2 hours of AMA Category 1 Credit; 2 prescribed hours of AAFP credit.)

JANUARY 19, 1981

THYROID NODULES

Salida, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

92 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit.)

JANUARY 30, 1981

UPDATE ON RENAL DISEASE

St. Mary's Hospital & Medical Center 4th Annual Winter Symposium.

Two Rivers Plaza, Grand Junction, Colorado.

Contact: Patric G. Moran, M.D., St. Mary's Hospital, 242-1550, ext. 2547 or 2246.

(8 hours of AMA Category 1 credit.)

CME Calendar Update

TUESDAY, FEBRUARY 3, 1981

Pueblo County Medical Society Membership Meeting

Dinner at 7:30 p.m.

Speaker immediately following dinner at Pueblo Country Club, 3200 Eighth Avenue, Pueblo, Colorado

SPEAKER: William R. Hendee, Ph.D., Professor and Chairman, Department of Radiology, School of Medicine, University of Colorado Health Sciences Center,

Denver, Colorado

TOPIC: Biological Effects of Low Level Exposure to Radiation

CME Category 1 Credit , one hour

THIS MEETING INCLUDES ALL PUEBLO COUNTY MEDICAL SOCIETY MEMBERS PLUS ALL MEMBERS OF DISTRICT IV COMPONENT SOCIETIES:

(Chafee, Fremont County, Huerfano County, Las Animas County, Otero County, San Luis Valley Medical & Southeastern Colorado Medical Societies).

Postcard reservations will be mailed to all Pueblo County Medical Society members for the dinner. All members of other societies should call or write to make dinner reservations.

CONTACT: Peggy R. Fogel, Executive Secretary
Pueblo County Medical Society
309 Grace Avenue, Pueblo, Colorado 81004
Telephone: 534-4767

EDITOR'S NOTE: For background information on the speaker and the subject of the address, see COLORADO MEDICINE, December, 1980, VOLUME 77, No. 12
Title: "Radiation and the Physician - What should be known about treatment."

CERTIFICATE OF SERVICE AND ROBINS AWARD

The deadline for receipt of nominations for the Colorado Medical Society's CERTIFICATE OF SERVICE award and the ANNUAL ROBINS AWARD is June 1, 1981.

The Certificate of Service is the highest award given by the Colorado Medical Society to a physician for "outstanding contribution to the Constitutional purpose of the Society."

The purpose of the Robins Award is to honor a physician in our state "for outstanding community service."

Send nominations to the Confidential Awards Committee, Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado 80218. These awards will be presented during the Colorado Medical Society's Annual Session, September 8-12, 1981, at Keystone.

Professional Education Update

UNDERSTANDING THE CANCER PATIENT

The chief of Psychiatric Service at New York's Sloan-Kettering Cancer Center discusses the management of psychologic and emotional problems of the cancer patient. Among the topics outlined are: the subspecialty of psychiatric oncology; the role of the primary care physician in meeting the cancer patient's emotional needs; informing the patient of a cancer diagnosis; the cancer patient with significant psychologic problems; the use of psychotropic drugs; and the special problems of children with cancer. This will be a valuable resource for all physicians and allied health personnel.

PUBLIC ATTITUDES TOWARD CANCER AND CANCER TESTS

Despite recent surveys indicating that Americans are doing more than ever to protect themselves against cancer, a majority of people are still either misinformed or uninformed about the prevalence of cancer, its curability, and the nature and purpose of various cancer detection tests. This is a summary of results from a recent survey conducted by the American Cancer Society of public attitudes toward cancer and cancer tests. Among the topics covered are: knowledge of cancer's warning signals; the most familiar cancer sites; colorectal cancer detection tests, BSE and breast reconstruction; and the perceived curability of lung cancer.

FOR MORE INFORMATION OR TO ORDER THESE PAMPHLETS, PLEASE CONTACT:

The American Cancer Society
1809 East 18th Avenue
Denver, Colorado 80218
321-2464

Is there a doctor on the road or at the game?



The Committee on Medical Aspects of Sports of Colorado Medical Society hopes to hear from physicians who share its members' interest and concern about medical coverage of running events and interscholastic athletic contests.

Please let us know if you are interested in participating in your community.

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Please mail to:
David C. Greenberg, M.D.
Chairman
Medical Aspects of Sports Committee
Colorado Medical Society
1601 E. 19th Avenue
Denver, CO 80218

Name: _____

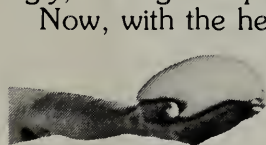
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new officers

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336-9051

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Dorothyann Lindes, M.D.
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Paonia, Colorado 81428
527-4103

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the lobby

The election is over, the new legislators have been trained by legislative staff, legislative leadership for the next 2 years has been chosen. It's time to step back and look at just what the November 4th election results mean for Colorado citizens in general and Colorado physicians in particular.

The numerical makeup of the Colorado legislature changed by only one—the Republican/Democrat ratio in the House is 39/26 as compared to 38/27 in the current assembly; the Republican/Democrat ratio in the Senate remains at 22/13. With five senators having chosen to retire, four current house members and only one new member, James Beatty—a Republican attorney from Ft. Collins—join the senate membership. In the House of Representatives, 21 new members (or almost one-third of the total membership) were elected. The brand new face results from ten retirees, seven incumbent defeats, and the four representatives who were elected to the senate.

Leadership in the two houses has been chosen with a first-time-ever dual Senate majority leader result. After eight ballots, five cast on November 7 and three on November 23, Senator Ralph Cole of Littleton still had 11 votes as did Senator Dan Noble of Norwood. The decision was made to have Senator Cole serve as majority leader in 1981 and Senator Noble in 1982 with the two working together on committee chairmanships and memberships. The names you will hear and read most often in the next 2 years are:

Senator Fred E. Anderson, Loveland
President of the Senate

Senator Dan Schaefer, Lakewood
President Pro Tem of the Senate

Senator Ralph Cole, Littleton—1981
Senator Dan Noble, Norwood—1982
Senate Majority Leader

Senator Joel Hefley, Colorado Springs
Assistant Majority Leader (Whip)

Senator Robert J. Allshouse, Aurora
Majority Caucus Chairman

Senator Regis Groff, Denver
Senate Minority Leader

Senator Barbara Holme, Denver
Assistant Minority Leader

Senator Martin Hatcher, Gunnison
Minority Caucus Chairman

Representative "Bev" Bledsoe, Hugo
Speaker of the House

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Representative Ron Strahle, Fort Collins
House Majority Leader
Representative Steven Erickson, Loveland
Assistant Majority Leader
Representative Claire Traylor, Wheat Ridge
Majority Caucus Chairman
Representative Federico Pena, Denver
House Minority Leader
Representative Rich Castro, Denver
Assistant House Minority Leader
Representative Betty Orten, Westminster
Minority Caucus Chairman

Members of the Joint Budget Committee: Senator Ruth Stockton (R), Lakewood, Chairman; Senator Steve Durham (R), Colorado Springs; Senator James Kadlecak (D), Greeley; Representative Bob DeNier (R), Durango, Vice-Chairman; Representative Tom Tancredo (R), Arvada; Representative Jean Marks (D), Northglenn.

The Senate became slightly more conservative, more confrontive, more urban, more strident in its leadership; the House is less predictable because of so many new personalities but should prove to be less conservative than it has been in the last two years. The Senate basically returned the leadership we are used to working with; the House produced new chiefs. It's especially gratifying to see a physician's wife, Representative Claire Traylor, in a House leadership role.

The Joint Budget Committee lost Representative Betty Neale (R), Denver, which is a blow to the city of Denver and Mayor McNichols. (She chose to work for the election of Representative John Hamlin for Speaker of the House, and loyalty to the winner is rewarded). Representative Neale is the expert on the medically indigent issue, and we shall have to change tactics on this. On the bright side, physicians have two super friends in the two new members appointed to the committee which could mean a healthy future for our Medicaid problems.

We will have Senator Harvey Phelps and new Senator Martha Ezzard representing physicians in the Senate but lost Senator Roy Shore who was elected to the Board of Regents of the University of Colorado with no opposition (a real plus for the medical school). Representative Claire Traylor remains in the House.

We lost two super friends to defeat—Representative Carol Edmonds (D), Grand Junction, and Representative Jim Shepard (D), Thornton, plus several others whom we could count on most of the time. We gained a physician's son, Bill Artist (R), Greeley;

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ARAPAHOE MEDICAL SOCIETY

David Gene Shapnick, M.D.
7583 South Ogden Way
Littleton, Colorado 80122

CLEAR CREEK MEDICAL SOCIETY

Catherine E. Wilkerson, M.D.
29552 Fairway Drive
Evergreen, Colorado 80439

William M. Wilkerson, M.D.
29552 Fairway Drive
Evergreen, Colorado 80439

Philip J. Burstein, M.D.
315 Franklin Street
Denver, Colorado 80218

PUEBLO MEDICAL SOCIETY

Alexander Kelly Morley, III, M.D.
1600 West 24th Street
Pueblo, Colorado 81003

Karen B. Brody, M.D.
c/o State Hospital
1600 W. 24th Street
Pueblo, Colorado 81004

Michael T. Rendler, M.D.
401 Michigan Avenue
Pueblo, Colorado 81004

INTERMOUNTAIN MEDICAL SOCIETY

Jonathan Feeney, M.D.
181 West Meadow Drive
Vail, Colorado 81657

WELD COUNTY MEDICAL SOCIETY

Thomas R. Lininger, M.D.
1900 16th Street
Greeley, Colorado 80631

Robert E. Blattner, M.D.
1900 16th Street
Greeley, Colorado 80631

Mary A. Blattner, M.D.
1900 16th Street
Greeley, Colorado 80631

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foundation report

During the last session of the Colorado Legislature, a bill entitled "Alternatives to Nursing Home Care" and referred to most commonly as Senate Bill 38 was passed. The major intent of this legislation is further expansion of home health services through the inclusion of speech, occupational, and physical therapies within the area of service and the furnishing of these services as an alternative to nursing home care. The bill provides a day health pilot project and creates a new group of eligibles for home health services. This group consists of people whose income exceeds the Supplemental Security Income standard and are currently eligible for nursing home care. The bill further provides case management services, client assessment, and reimbursement.

Access to Senate Bill 38 services as an alternative to nursing home care requires certification which occurs during the PSRO review of Long Term Care placements. This certification, based on objective criteria, will direct some potential nursing home placements into Senate Bill 38 service alternatives. Physicians who wish to divert potential nursing home placements into Senate Bill 38 services or home health services can work through Home Health Agencies as in the past.

standards of practice

(Continued from page 2)

For instance, the Department hires a professional consultant who is a physician to provide the board with investigational expertise. Thus, Department attitudes should be considered in dealing with the Board of Medical Examiners. Head of the Department is Gail Klapper, an attorney and wife of Denver neurologist Jack Klapper.

Denver Medical Society Plans Activities

Officers of the Denver Medical Society regard the efforts of the DMS Auxiliary as an important adjunct to the Society. The president and president-elect of both the Society and its Auxiliary form the Auxiliary Relations Committee which again this year has planned a series of joint activities for members of the So-

cietty and members of the Auxiliary.

The first social event occurred on December 4, 1980 when a Holiday Buffet was enjoyed at the Cherry Hills Country Club. This event was held as a benefit for the Library Endowment Fund of the Denver Medical Society. A portion of each ticket served as a contribution to the work of the Library. Each of the attendees received information about the Library encouraging them to become more active in its use and in supporting it.

The second of the events, which are carried out primarily by the Auxiliary, is Legislative Night, scheduled for January 20, 1981. This is a late afternoon-early evening social event where doctors and their wives meet informally with the Denver legislators and in a relaxed atmosphere discuss both legislative and non-legislative matters. It takes place in the DMS building.

On the planning board is a special evening at the Denver Art Museum in February. This will be a repeat of a very successful event held two years ago. Following an hour of sociability with wine and cheese, the group will be divided into small clusters to tour the Thyssen-Bornemesza collection of Old Masters.

Doctors' Day, scheduled for April 14, 1981, is one of the oldest traditions of the Denver Medical Society and its Auxiliary. This has been an outstanding buffet for many years. Much of the food is prepared by Auxiliary members, who bring their specialties. The evening begins with a social hour in the DMS Library and dinner takes place on the main floor of the DMS building. The event is highlighted by the renewal of old acquaintances and the appearance of many of the senior and some of the retired physicians and their wives.

The idea of scheduling a visit to Central City via bus this summer for dinner and the opera is being pursued. DMS members will be contacted soon to determine their interest in a second such excursion.

These events represent a great amount of effort to share some group experiences with each other within the medical society and auxiliary. As always, the Denver Medical Society Auxiliary is interested in having more spouses join and participate in these joint events and in the special projects which the Auxiliary performs on its own.

One of the most recent continuing projects has been the increased assistance given the Hall of Life exhibit on medical subjects by members of the DMS Auxiliary. This developing exhibit, housed in the Blue Cross/Blue Shield Building is hosting more and more young visitors. Classrooms will soon be constructed to allow more concentrated educational efforts for groups of school children and adults. The DMS Auxiliary is on call to furnish guides and hostesses when needed by the Hall of Life exhibit as it becomes better known in the Denver community.

The cochlear prosthesis: hearing for patients with profound nerve deafness*

Current State of the Art

Thomas J. Balkany, MD, I. Kaufman Arenberg, MD, Nolan C. Rucker, DVM, MD, James D. Pauley, PhD, and Donald J. Northey, MA, Denver, Colorado

The cochlear prosthesis is an electronic device which provides a form of hearing for people with profound sensorineural deafness. The prosthesis is microsurgically implanted into the mastoid-middle ear and the electrodes are placed through the round window into the inner ear. The cochlear prosthesis is designed to stimulate electrically the auditory nerve in response to sound and subserve the most primitive auditory functions of the inner ear in transforming discrete mechanical sound waves into discrete electrical signals which are delivered directly to the auditory nerve and then carried to the central auditory reception centers of the brain. Historical development of the cochlear implant is described, as are its major goals, and theoretical mechanism of action. In addition, a review of patient selection, clinical experience and effectiveness is presented.

Historical Review and Major Goals

Electrical stimulation to produce hearing was first used in 1957 when the first implantation of an electrode into the cochlea of a totally deaf patient in France was performed.¹ However, experimentation with electricity to produce hearing began as far back as the 18th Century when Volta first applied current to his own ears using metal rods. After regaining consciousness, he reported that he had experienced an auditory sensation that sounded similar to boiling liquid.² In 1930, a breakthrough was made when Weaver and Bray³ discovered that the function of the cochlea was to convert mechanical sound energy into electrical nerve impulses. Andreef,⁴ in 1935, and Stevens and Jones⁵ in 1939 reported that electrical stimulation of patients with profound cochlear deafness produced auditory sensations.

The first reports on the direct stimulation of the auditory nerve in a human subject in the United States were by Simmons⁶ in 1966 and House⁷ in 1973. During the 1960's, House conducted extensive electrical stimulation tests on several patients undergoing stapes surgery. He later reported that loudness was proportional to its frequency in the low ranges. House⁸ also found that stimulation did not cause pain, dizziness or facial nerve excitation when the electrical signal was presented above 30 Hz.

At the present time, several research investigators are active in the field of the electronic cochlear prosthetics. It is generally agreed that the general physiology of hearing is now well-enough understood so that development of a cochlear prosthesis is possible. Electronic technology and microsurgical technics make insertion of such a prosthesis practical. It is anticipated that eventually, with technological advances, the prosthesis will be able to fulfill more sophisticated auditory functions, such as reception and discrimination.

Theoretical Mechanism of Action

The purpose of the cochlear prosthesis is to replace or bypass the function of the nonfunctioning cochlea. The normal cochlea transduces mechanical energy coming in on sound waves into the coded nerve signals that are carried to the brain via the auditory nerve. This device to replace or bypass the nonfunctioning cochlea consists of two basic parts: an internal implanted portion and an external portion. The external portion consists of a microphone to receive discrete sound waves, a transducer which converts the discrete sound waves into coded electrical energy, and an external coil which transmits the coded electrical information via magnetic induction across the normal skin behind the ear to the internal matching induction coil in the mastoid cavity. (Fig. 1) The internal device consists of an implanted matching induction coil which re-

*Drs. Balkany and Arenberg are at the Colorado Ear Clinic as is Mr. Northey. Drs. Rucker and Pauley and Mr. Northey are at the Colorado Otologic Research Center, with which Drs. Balkany and Arenberg are also associated. Both of these groups are associated with Porter Memorial Hospital/Swedish Medical Center, Denver.

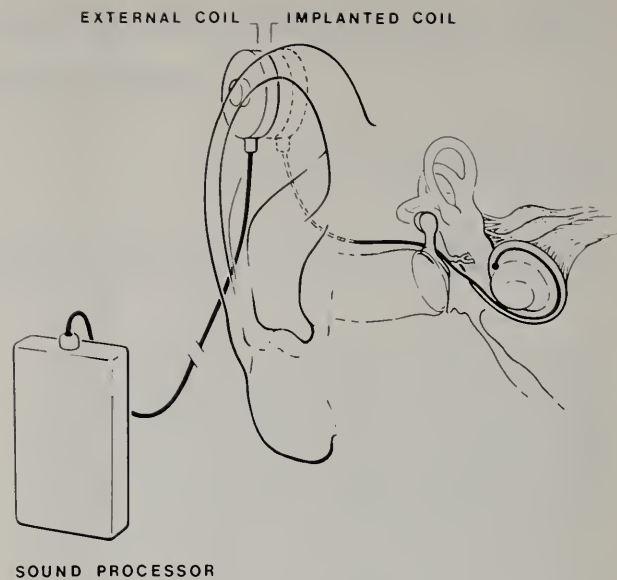
Fig. 1. Cochlear Prosthesis. Note external device consisting of sound processor and magnetic induction coil and internal device consisting of implanted magnetic induction coil and electrode in cochlea.

ceives the magnetic signal from the external coil and passes it along to the special coated micro-electrodes which have been microsurgically implanted through the round window into the inner ear.

At the present time, most implant electrodes are inserted into the scala tympani of the cochlea under direct vision with the aid of the operating microscope. This site is chosen to take advantage of the way individual auditory nerve fibers are spread out into the cochlea. In the auditory nerve itself, approximately 25,000 individual nerve fibers are packed into a tight 1 millimeter bundle. In the cochlea, however, the same number of fibers is widely distributed over 35 millimeters. This distribution is very orderly. Fibers in each area of the cochlea are arranged according to pitch reception. This organization has been carefully mapped and is an important consideration in the overall design of the implant.

A second reason for placing the active electrode in the scala tympani is that microsurgical access to it is relatively simple and direct. A complete mastoidectomy is performed and the facial recess, the space between the facial and chorda tympani nerves, is widely opened. This gives direct visualization of the round window. The round window membrane is then opened and the electrode is inserted through it into the scala tympani of the cochlea. It should be noted that some other types of cochlear implants are inserted through the scale vestibuli and modiolus directly into the auditory nerve. This alternative method does not take advantage of the normal spread of neurons in the cochlea and the surgical approach is somewhat more difficult than for scala tympani placement.

Current methods of electronic transduction and microsurgical technics of implantation have been well worked out. The most significant unresolved problem of the cochlear prosthesis is determination of the ideal electrical signal to deliver through the nonfunctional cochlea to the auditory nerve. The device we are presently using delivers an amplitude modulated carrier wave in which duration and amplitude provide the signal. Other electrical signals are being actively investigated, however, in an attempt to further refine the capabilities of the implanted device.



Patient Selection

Cochlear implantation is currently limited to profoundly deaf adults who originally could hear and had developed normal speech. Because the effects of long term electrical stimulation so near the brain stem are not known, implantation of infants and children will not be attempted until more long term clinical data on safety and efficacy are available. Information is being gathered from implanted adults, as well as from behavioral, electrophysiologic, and histologic studies on experimental implanted infant monkeys, congenitally deaf Dalmation dogs, and other experimental models.

Patients are tested with standard threshold audiometry using pure tone and speech signals to determine that the hearing deficit is at least 95 dB in each ear. It is our feeling that patients with hearing losses less severe than 95 dB may benefit just as much from powerful body hearing aids as they would with implants.

Next in the selection process, the hearing loss is localized to the cochlea or the auditory nerve. The cochlear implant is designed to be used for sensory hearing loss due to cochlear pathology; i.e., to bypass the nonfunctioning cochlea and appropriately stimulate the auditory nerve, brain stem, or central auditory reception areas. The majority (2/3) of "nerve hearing losses" are caused by cochlear dysfunction, thus most patients with profound "nerve deafness" are candidates for implantation.

Because a profoundly impaired or nonfunctioning cochlea does not generate clinically signifi-

cant electrical impulses to travel up the auditory pathway, standard methods of distinguishing cochlear from other types of neural hearing loss are not valid. In order to identify those patients with profound cochlear hearing loss who also have VIII nerve loss (and therefore would not be candidates for the implant), the Electrical Promontory Stimulation Test has been revised by House.⁸ In this test, a low voltage low frequency alternating current is applied to the cochlea with a fine needle electrode which is passed through the tympanic membrane onto the promontory. If the neural pathways are intact, an auditory sensation is heard. If the neural pathways are destroyed, no sound is heard. In a report of 225 patients tested with electrical promontory stimulation test, 2 out of 3 of those totally deaf were shown to have cochlear loss, and 1 out of 3 had a neural loss.⁹

In addition to audiometric evaluation, the prospective subject undergoes complete neurotologic evaluation, as well as vestibular, radiographic, and psychological testing. The otologic examination is performed to determine that no ear infection, acoustic neuroma, or other treatable problem is present that would interfere with the potential success of the implant. Patients with diseases affecting cranial nerves other than auditory nerves are usually not considered good candidates for implantation. Potentially treatable causes for profound sensory hearing loss such as neuro-syphilis also must be ruled out prior to implantation. Vestibular testing consists of electronystagmography and complete neurological evaluation. In this way, objective baselines of vestibular function or dysfunction are obtained and the ear with the poorer remaining function is usually selected for implantation.

Complete psychological evaluation is also necessary prior to implant surgery. Emotional stability, intelligence, self-esteem and underlying expectations of the patient are well evaluated. Baseline psychological evaluations are compared to the results of yearly re-examinations. No adverse psychological or neurological effects have been noted to date. The longest followup of a cochlear implant by House (personal communications without adverse physical or psychological reactions is now 9 years.

Implantation Surgery

The microsurgical technic used by the Colorado Ear Clinic cochlear implant team has been

developed by William F. House, MD, of the Ear Research Institute in Los Angeles.⁸ Surgery is done under general anesthesia through an incision behind the ear and involves a simple, complete mastoidectomy. The implant is housed in the mastoid space. Access to the middle ear is obtained between the facial nerve and chorda tympani nerve, i.e., through the facial recess. The wires are passed from the implant through the mastoid space into the middle ear. The electrode is then placed in the scala tympani of the cochlea through the round window membrane. A muscle plug is fitted into the round window niche to prevent leakage of cochlear fluid. The external coil to which the electrodes are connected is firmly attached to the mastoid bone. The operation lasts about 2 hours and the patient returns home 2 days after surgery. The potential complications of the implantation surgery are basically the same as those for mastoidectomy and include: temporary taste disturbances from chorda tympani injury, numbness of the pinna due to the incision, facial nerve injury, cerebral spinal fluid leak, infection, and the complications of general surgery. At this time, no serious surgical complications have been reported.

Patients begin rehabilitation soon after recuperating from surgery. This program involves both the subject and family members and is directed toward learning to use the newly acquired auditory information. Recognition of environmental sounds and integrated instruction in speech, lip reading, listening, and voice production are emphasized. All patients are given practice programs to continue the training process at home. Followup correspondence, group meetings and post-testing are done on a routine basis.

Results of Implantation

The ultimate goal of the cochlear prosthesis, to create entirely normal hearing, is probably beyond the scope of the near future. For the moment, we have to settle for something less than that. How much sound information can implanted patients be expected to receive?

Phylogenetically, the interpretation of sound information has evolved from very simple beginnings. Auditory function of low forms of animal life is confined to awareness of sound. Somewhat higher on the evolutionary ladder, animals are able to discriminate environmental sounds. This ability gives them a survival advantage. Still higher forms are able to receive simple and highly

limited auditory codes. These codes allow some degree of auditory socialization and convey limited information. Man is able to use all of these basic auditory mechanisms and, in addition, is able to communicate in a highly complex method we call language.

All of the basic forms of auditory information processing are currently available with the cochlear prosthesis. Implanted patients are able to receive sound where previously they could not, to discriminate environmental noises such as dial tones and footsteps, and many are able to carry on very limited precoded conversations. However, the patients do not achieve normal or near-normal speech discrimination. Although sound perception is possible soon after implantation, experience and training are required to achieve maximum utilization and understanding of environmental sounds and language cues. While implanted patients do recognize and accurately distinguish environmental sounds, they do not understand speech. They are able to hear and control their own voices, and most have measurable improvement in their own speech and in speech reading. The cochlear prosthesis can be very helpful in facilitating lip reading.

A psychological gain is obvious in nearly all persons implanted. This is thought in most cases to result from getting back in touch with the environment and all the attention and effort by professionals to improve their communication capabilities. Some noticeable changes include an increase in self-esteem and increased sense of security. The sense of security often results from the use of environmental cues such as recognition of a passing automobile, a fire alarm, approaching footsteps, and the opening and closing of a door.

An interesting side effect of the cochlear prosthesis has been the relief of tinnitus in the implanted patients. Although the mechanism is un-

known, relief has occurred in the majority who had tinnitus prior to the implantation. Further study may show the implant to be of value in treatment of severe tinnitus when it occurs in conjunction with a profound unilateral sensorineural hearing loss.

Research in Progress

The cochlear prosthesis research team at the Colorado Otologic Research Center is currently engaged in experimental implantation of infant monkeys. The purpose of this study is to determine the safety of implantation during the critical period of language development in early childhood. If it is demonstrated that experimental long term electrical stimulation of the auditory nerve in a monkey is safe, then the "ideal" candidate would be one who is congenitally deaf. The ideal time for implantation would then be infancy, during the critical period of brain maturation and language learning.

Other current research on the prosthesis includes preliminary studies on genetically deaf Dalmation dogs as well as the use of multi-channel information systems and improved methods of transcutaneous delivery of information.

Summary

The cochlear prosthesis is a device which is now in clinical use in Colorado as well as several other centers to provide a sense of hearing or sound awareness to the profoundly deaf. In over 100 patient years of experience it has been shown to be safe and reliable. Although patients do not achieve anything approaching normal hearing, the device has proven clinically useful and has made a major change in the life styles and communication capabilities of most implanted patients. ●

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Physicians' Concern for "Leap Program"

During the winter months, many Colorado low income families experience the possibility of utility discontinuation. Physicians have the opportunity to refer a person in need to the "LEAP PROGRAM," or to help them obtain medical certification necessary to prevent a shutoff.

The new, low-income energy assistance program is available to these families to help them pay their heating costs. Applications are available through county departments of social services; or, interested persons may call the LEAP HOTLINE: In Denver call 839-2885, or, in Colorado, call the toll-free number, 1-800-332-6730.

In addition, the Public Utilities Commission has passed procedures which must be followed by utility companies when attempting to shut off delinquent customer's service may not be disconnected if a licensed physician certifies in writing that "...termination of service would aggravate an existing medical condition or create a medical emergency for the customer or a permanent resident of the customer's household." Such certification prevents disconnect for sixty days with a thirty day extension possible. Therefore, you, as a physician, may have the opportunity to refer a person in need to the LEAP PROGRAM or to help them obtain the medical certification necessary to prevent a shutoff.

B/W Pharmacy Education Program Award

JOHN P. REYES OF GATES MEDICAL CLINIC PHARMACY in Denver, Colorado, has won a \$750 award in the Burroughs Wellcome Pharmacy Education Program.

The award money will be presented to the UNIVERSITY OF COLORADO in Mr. Reyes's name to establish a revolving loan fund for deserving pharmacy students.

The \$117,000 Pharmacy Education Program is sponsored by Burroughs Wellcome Co. Three pharmacists from each state and the District of Columbia and Puerto Rico were selected as winners this year. More than 40,000 pharmacists across the country submitted entries.

REVIEW OF JAIL SURVEY FINDINGS AND DISCUSSION OF PROJECT GOALS

I. Description of Colorado Jails

- A. 80% are small jails with average daily populations less than 20. In many cases less than 10.
- B. Colorado is one of only 8 states which does not have state jail standards (statutory).
- C. Enabling legislation to form a jail standard commission to develop jail standards will be before the legislature this year. Standards have already been drafted by an appointed committee.
- D. Many persons familiar with the legislation feel it is unlikely to pass.
- E. Standards dealing with direct medical care are vague and constitute only 1½ pages of 150 pages of proposed jail standards.

II. Survey Findings

- A. Nine jails have been surveyed to assess their compliance with AMA jail health care standards.
- B. Most of the jails were not meeting the following AMA essential standards concerning:
 - 1) receiving screening of inmates
 - 2) frequency of sick call held
 - 3) daily triaging of health complaints
 - 4) conducting health appraisals of inmates incarcerated 14 days
 - 5) health education training for jailers
 - 6) medical supervision of drug/alcohol dependent inmates
 - 7) supervision and monitoring of medical treatments provided by other than a physician.
- C. *Small* jails in Colorado (80% of jails) generally have no in house health providers. Community hospitals and clinics are utilized for all inmate health complaints. County commissioners resist providing funds for contractual health providers or increasing the public health nurse's budget to expand her services to jails.
- D. Large jails have in-house medical staff. Staff is often insufficient for 24 hour coverage. In some large jails EMT's constitute in-house staff and proper supervision and monitoring, existence of protocols is questionable.

III. Recommended project goals and activities relating to problems described above.

- A. Endorse need for jail health care standards.
- B. Have committee representative on any commission charged with development of jail standards and lobby for:
 - 1) inclusion of AMA essential standards
 - 2) availability of resources to assist jails in meeting standards.
- C. Provide intensive assistance to 3 jails to enable AMA accreditation—a large, medium and small sized jail with problems representative of other Colorado jails. Use these jails as models to provide technical assistance to other jails.
- D. Provide workshops to which all Colorado jails are invited on:
 - 1) AMA standards and development of health care policies and procedures
 - 2) health education training to jailers
 - 3) documentation of health care provided and record keeping.
- E. Develop jail linkages with regional resources that could but have not traditionally provided services to inmates.
 - 1) health providers
 - 2) health education training to jailers.

American Association of Medical Assistants, Inc.

Colorado Society

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| | |
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| 8:30- 9:00 | Registration |
| 9:00-10:30 | ICD 9 |
| 10:45-12:15 | BCBS - Tom McDonald |
| 1:30- 3:30 | Workmen's Compensation Charles McGraft |
| 3:45- 4:30 | Coordination of Claims Dean Russman |

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Registration deadline March 5, 1981

Total _____

Physician's Bulletin

Lakewood Department of Public Safety

Over the past nine months a cardiac patient visited numerous physicians representing himself as a retired businessman new to Denver. He has scars from a triple bypass operation and lung surgery. He asked the doctors for Isordil, Dyazide and QUAALUDE. He would then leave the doctors' offices without paying his bill and go to a pharmacy to fill the Quaalude prescription only.

This man used the following names:

Robert Waters

Richard P. Myers

Ronald P. Martin

Donald Gamble

Donald A. Boyer

He gives his date of birth of November 2, 1922, and is a caucasian male, about 58 years old, 5' 10" tall, weight 165, with short, thinning, dark brown "salt and pepper" hair. He is well suntanned and a very smooth talker. He has scars on his chest and inner arms and possibly a heart-shaped tatoo on one upper arm. He usually lists Travelers as his insurance carrier. He gives an address and phone near the doctor's office, however, these addresses and phones are not his.

This man has not yet been identified by police. If he comes to your office, please stall him and notify your local police or sheriff's department immediately. If the man leaves your office, try to obtain his car license number and report it to the Lakewood Department of Public Safety, Intelligence Division, Sergeant John Miller, 234-8542.

(Continued from page 9)

a nurse, Candy Dyer (D), Longmont; a nurse's husband, Don Eberle (D), Denver. It has been interesting and fun to meet the new legislators that I'd not already met. I walked many blocks on many week-ends for many legislators, and I'm counting on the fact that many physicians and spouses did the same. The ophthalmologists did a *superb* job throughout the state, and this should be a big plus for all physicians.

Remember that big issue affected by the election—reapportionment must take place in 1981. It looks as if Colorado will gain a sixth seat in the U.S. House of Representatives, and remember that the Colorado General Assembly does the reapportioning of congressional seats. Look for new lines aimed at giving the Republicans a chance of winning two more house seats, and expect geographic battles to surface. The Western Slope will be especially noisy in its attempt to be represented by their own congressman. An 11 member body called the Colorado Reapportionment Committee will reapportion the General Assembly in line with the 1980 census figures. The Chief Justice of the Supreme Court (a Republican) appoints four members; the governor (a Democrat) appoints three; and four are from the legislature—the speaker (rural) and the minority leader (Denver chicano) of the House and the majority leader (a suburban and rural duo) and the minority leader (Denver black) of the Senate. Thus, reapportionment made the leadership races unusually important especially to minority and rural members—they obviously were successful.

The following shows just exactly where the changes in the legislature took place.

1981 LEGISLATIVE CHANGES

STATE SENATE

Defeated: None

New: James Beatty (R), Fort Collins

Moved from the House to the Senate:

Representative Martha Ezzard (R), Englewood
Representative Ray Powers (R), Colorado Springs
Representative Steve Durham (R), Colorado Springs
Representative Cliff Dodge (R), Denver

Retired (by their own choice):

Senator Hugh Fowler (R), Littleton
Senator Don Harding (R), Colorado Springs
Senator Harold McCormick (R), Canon City
Senator Roy Shore (R), Greeley
Senator Bob Wham (R), Denver

STATE HOUSE OF REPRESENTATIVES

Defeated:

Representative Forrest Burns (D), Lamar
Representative Mike Callihan (D), Gunnison
Representative Carol Edmonds (D), Grand Junction
Representative "Casey" Hayes (D), Commerce City
Representative Jim Shepard (D), Thornton
Representative Nick Theos (R), Meeker
Representative Dorothy Witherspoon (D), Lakewood

New:

Vickie Armstrong (R), Grand Junction
Bill Artist (R), Greeley
Jim Chaplin (R), Broomfield
Candace Dyer (D), Longmont
Don Eberle (D), Denver
Lee Gillis (R), Lamar
Chuck Heim (R), Colorado Springs
John Herzog (R), Colorado Springs
Jim Lee (R), Lakewood
Robert Martinez (D), Commerce City
Donald Mielke (R), Lakewood
Peter Minahan (R), Security
Chris Paulson (R), Englewood
Ruth Prendergast (R), Denver
Jim Robb (R), Grand Junction
Greg Rogers (R), Denver
David Skaggs (D), Boulder
Kathleen Sullivan (D), Meeker
Glen Underwood (R), Olathe
Wilma Webb (D), Denver
Ruth Wright (D), Boulder

Retired (by their own choice):

Representative King Trimble (D), Denver
Representative Bob Burford (R), Grand Junction
Representative Anne Gorsuch (R), Denver
Representative Carl Gustafson (R), Denver
Representative Art Herzberger (R), Colorado Springs
Representative Bill Hilsmeier (R), Longmont
Representative Chuck Howe (D), Boulder
Representative Lee Jones (D), Boulder
Representative John McElderry (R), Lakewood
Representative Carl Showalter (R), Greeley

I'd appreciate hearing from any physician who took part in the campaign of any of the new legislators or who knows that legislator or who is the personal physician for that legislator. It is important that we have a willing and able keycontact for every one of these people.

Many thanks to all of you who contributed in any way to the 1980 campaigns and who continue to work with the winners. It makes my work much, much easier.

Carol Tempest, Director
CMS Government Affairs

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ARAPAHOE MEDICAL SOCIETY

Gregory B. Emery, M.D.
950 East Harvard Avenue, #470
Denver, Colorado 80210

(Continued from page 8)

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874-4473

EXECUTIVE SECRETARY

Marion Austin
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COLORADO MEDICAL SOCIETY INTERIM SESSION

March 14-15, 1981

Sheraton—Denver Tech Center

FRIDAY, MARCH 13

9:30 a.m. Medical Executives Group (MEG)
1:30 p.m. Board of Directors
7:00 p.m. Specialty Society President's Dinner
7:00 p.m. Board of Directors Dinner

SATURDAY, MARCH 14

7:00 a.m. Judicial Council Breakfast
8:30 a.m. Registration Opens
9:00 a.m. Credentials Committee
9:30 a.m. House of Delegates
11:30 a.m. Reference Committee Chairmen Luncheon
1:00 p.m. Reference Committee Meetings
5:00 p.m. Reference Committee Chairmen
6:00 p.m. Wine and Cheese Tasting Party

SUNDAY, MARCH 15

7:00 a.m. Component/District Caucuses
8:00 a.m. Registration Opens
8:30 a.m. Credentials Committee
9:00 a.m. House of Delegates

PROFESSIONAL OPPORTUNITIES

EMERGENCY PHYSICIAN: Regional trauma center serving Western Nebraska has key opening for career emergency physician. Excellent salary and work schedule, including pension, profit-sharing, paid CME, relocation allowance, paid malpractice, health, life, and disability insurance. Send CV to S. Lee, Box 8013, Fresno, California 93747.

1280-6-2B

INTERNAL MEDICINE-OREGON. Fastest growing community on Oregon Coast is looking for 1-2 internists to join existing medical staff of 7 FP's and 1 surgeon. Excellent recreation opportunities - hunting, fishing, boating, etc. 47-bed hospital is 1½ hours away from 400-bed medical center. Beautiful location. 12,000 population service area. Contact: Doug Kunsman, Administrator, Western Lane Hospital, P.O. Box 580, Florence, Oregon 97439. Call: (503) 997-3468.

1280-4-3B

FAMILY PRACTITIONER: Immediate opportunity for full or part-time commitment in established family practice, due to medical retirement of current practitioner. Call: (303) 420-3270 or write: 4045 Wadsworth, Suite 201, Wheatridge, CO 80033. 181-1-1B

GROW WITH US IN SUNNY ARIZONA. The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Attractive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living appeal to you, send your CV to: Professional Relations, INA Healthplan, Inc., 6115 North 7th Street, Phoenix, AZ 85014.

181-1-TFN

FAMILY PRACTICE ASSOCIATE needed to join two others in busy practice, including obstetrics. Contact Jack I. Paap, M.D., 1255 Lake Ave., Colorado Springs, CO 80906. Call: (303) 576-3901.

181-1-1B

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1970 Jaguar, XK-E, excellent condition; new clutch; 45,000 miles. British racing green, leather interior; exciting car and good investment. \$8,995.00. Call: 321-7498.

181-1-1B

FOR LEASE: Ski Steamboat Springs. Four bedrooms, four baths, townhouse sleeps 12. Completely furnished. GE kitchen, washer/dryer, TV. Ski to/from gondola, on/off slopes. Two-car heated garage. R.L. Penfold, M.D., 1908 Pawnee Drive, Fort Collins, Colorado 80525. Or call: (303) 484-2255.

1280-3-4B

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980-8-1B

colorado medicine

February, 1981

Volume 78, Number 2

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An Act



Taking the Pulse
CMS Council on Legislation

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage. Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy.—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy.—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain.—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic.—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic.—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal.—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[30200000]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
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4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II, 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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ARTHROPLASTY
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*Bernard C. Sherbock, MD, Denver, Col-
orado.*

*Presented at a medical conference, Zhong Shan
Medical College, Canton, China, September 12, 1980.

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THE COVER

In today's practice of medicine, the Executive, Leg-
islative and Judicial branches of government have be-
come entwined as one with the practice of medicine.
The question has become a universal WHY? Why
must this happen? Why must the laws of man attempt
to bear so heavily on the very laws of nature? Our
February edition is devoted, primarily, to this question
and how members of Colorado Medical Society are
coming to grips with the resultant problems. Be sure
to read WHY ... on page 28.

Address all correspondence relating to subscrip-
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organizations and other news items relating to edi-
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Editorial and Business Office
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new members

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1511 East Boulder
Colorado Springs, Colorado 80909

Richard P. Wenham, M.D.
3100 North Academy
Colorado Springs, Colorado 80907

Richard O. Evans, M.D.
1255 Yale Avenue
Colorado Springs, Colorado 80906

new officers

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Robert V. Johnson, M.D.
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Fort Collins, Colorado 80524
493-0112

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Fort Collins, Colorado 80524
484-2099

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1024 Lemay Avenue
Fort Collins, Colorado 80521
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Term expires 12/82

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Fort Collins, Colorado 80521
482-4111 Ext. 1540

INTERMOUNTAIN MEDICAL SOCIETY

PRESIDENT

Charles E. Hart, M.D.
181 West Meadow Drive
Vail, Colorado 81657
476-5695

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letters to the editor

To the Editor:

A recent article on radiation effects by R. W. Bistline, Phd. of the Rocky Flats Plant has some inaccuracies. This appears in a series of articles by Rocky Flats Plant writers and their associates.

The study Bistline cites of the mortality and radiation dose of the A-bomb survivors is flawed because it considers only the five year survivors. Only those who were still alive five years after the detonation of those two weapons were included. Such five year survivors are likely to be more hardy and resistant than a general population.

The statement that metropolitan areas have a statistically higher incidence of many types of cancers has been disputed.

Bistline does not explain what "peer epidemiologist" actually means. I believe he means epidemiologists who have been funded, retained or employed by the hundred billion dollar nuclear industry and the agencies that support it. The studies that he criticizes still stand, despite their unpopular implications for the industry. The comments Bistline makes are simply not valid, in my opinion.

Bistline lists agencies (actually, individuals) that have reviewed scientific reports critically. In fact, each of the individuals who have carried out the critiques he cites have some connection with the Atomic Energy Commission (now the Nuclear Regulatory Commission and the Department of Energy), currently the subject of a 40 million dollar lawsuit over a radiation effects issue.

My study in particular was also reviewed by a national study committee of the National Cancer Institute, and my research was approved for funding. This study is currently going forward with support by a graduate statistician and consultation from Dr. Alice Stewart and Dr. George Kneale of England, both of whom are noted for their work in this area. This work has been presented at national and international meetings of "peer groups".

Interestingly, Bistline fails to mention the study at Livermore which demonstrates a rate of melanoma five times greater than expected, or the three-fold excess in the ratio of melanoma to all cancers of Rocky Flats workers. There are also an eight-fold excess of brain tumors in relation to all cancers in Rocky Flats workers.

Although workers at these plants have been exposed to high levels of carcinogens for the past 28 years, there has not been a single comprehensive epidemiologic study conducted of the health of the

(Continued on page 47)

board of directors condensed minutes

1. Approved the motion to attempt to stimulate medical student participation in CMS Board, Council and Committee activities. Medical student, Lee Ann Pearse, agreed to report back to the Board of Directors a plan for student involvement.
2. Approved reappointment of Dr. Roger Mitchell as Chairman of Committee on Environment, and appointments of Paul Kotin, M.D., Carlton Dean, M.D., Victor A. Crumbaker, M. D., Lawrence Repsher, M. D., and William Hendee, Ph.D., to the committee.
3. Dr. Robert McCurdy highlighted actions of the recent AMA meeting.
4. Council on Legislation requested the following Board actions: Support of SB 197 "Financial Aid to Colorado Residents Qualified to Study Osteopathic Medicine in Schools Outside Colorado;" Oppose position of SB 179 which unfairly favors existing HMOs over and above future HMOs coming aboard in this state; approve request to appoint immediately a member from Clear Creek Valley Medical Society to the Council on Legislation to complete the balance of representation from the metro area.
5. Approved support of Multiphasic Screening legislation to be adapted from AMA model bill to conform with Colorado statutes.
6. Approved policy re indemnification of Officers, Directors, members of Councils, Committees and Staff.
7. Received the following reports: AMA Resident Physician Section, SBS-AMA Interim Meeting, Component/Specialty Society Officers Meeting, BC/BS Meeting, Finance Committee, Membership Classification requests.
8. Approved reports for submission to House of Delegates from Public Information Committee, Committee on Physician Health and Rehabilitation and Risk Management Committee.
9. Heard report on CMS Building program, discussed future of PSRO, received report of Executive Vice President.

MEMBERS PRESENT: President: K. Mason Howard
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Anthony J. Palmieri, Joseph H. Poynter,
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Immediate Past President: Ray G. Witham
District II: Jerry A. Applebaum
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CONTINUING MEDICAL EDUCATION UPDATE

MARCH 20-22, 1981

American Psychiatric Society, Area VII 3rd Annual meeting

PROBLEMS IN PSYCHIATRIC CONSULTATION

March 20-22, 1981, The Fairmont Hotel, Denver

Co-hosted by the Colorado Psychiatric Society and the Department of Psychiatry, University of Colorado School of Medicine.

17 credit hours AMA Category I.

Fee: \$150.00

Contact: Jeanette Currier, Executive Secretary, Colorado Psychiatric Society, 1555 East Lake Place, Littleton, Colorado 80121, or call (303) 795-8404.

CORRECTION NOTICE

This is to notify you of a correction in the dates for the following:

HIGH RISK INFANT CARE

March 9-13, 1981

An intensive program in perinatal medicine presented jointly by the Department of Pediatrics and Obstetrics and Gynecology with the intention of reviewing and updating practical clinical problems in the rapidly changing field of perinatology and to correlate these problems with basic principles and emerging concepts in the relevant underlying scientific disciplines.

The course is designed for the clinician involved in the recognition of the high-risk pregnancy and the management of the sick newborn. Topics will be presented in several formats, with didactic teaching sessions, informal discussions, nursery ward rounds and hands-on experience in workshops utilizing animal models. The material presented will be relevant to both physicians and nurses involved in the areas of obstetrics and pediatrics, and joint participation of physician-nurse teams is encouraged.

The course is limited to 32, so that ample time can be given to the needs of each participant.

FEE: \$300.00

Contact: Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colorado 80262, or call (303) 394-5241.

DATES: MARCH 9-13, 1981

(These classes had previously been announced as March 16-20, but the dates have now been corrected.)

BULLETIN CONCERNING CONTINUING MEDICAL EDUCATION REQUIREMENTS

AT A REGULAR MEETING OF THE BOARD OF MEDICAL EXAMINERS ON JANUARY 8TH, 1981 THE MATTER OF CONTINUED MEDICAL EDUCATION REQUIREMENTS WAS DISCUSSED. THERE HAD BEEN A GREAT DEAL OF CONFUSION AS TO THE INTERPRETATION AND THE TIME ELEMENT.

THE BOARD RULED THAT FOR THE RENEWAL PERIOD THIS YEAR, ADDITIONAL TIME WILL BE ALLOWED TO OBTAIN THE 20 HOURS OF CME. PHYSICIANS MAY HAVE UNTIL MARCH 1ST, 1981 TO OBTAIN THE REQUIRED NUMBER OF HOURS. HOWEVER, ALL INFORMATION MUST BE IN THE BOARD OFFICE BEFORE MARCH 1ST, 1981 TO COMPLY WITH THE REQUIREMENTS OF THE MEDICAL PRACTICE ACT.

HOURS ACCRUED DURING 1981 AND USED FOR THIS REGISTRATION PERIOD MAY NOT BE USED FOR THE NEXT RENEWAL PERIOD. IN OTHER WORDS, AN ADDITIONAL 20 HOURS MUST BE OBTAINED FOR THE REMAINDER OF THE YEAR FOR REPORTING IN THE NEXT REGISTRATION PERIOD. NO CARRYOVERS WILL BE ALLOWED FOR ENSUING YEARS. THE REQUIREMENT REMAINS 20 HOURS PER YEAR.

THE BOARD ALSO RULED THAT SELF-ASSESSMENT COURSES APPROVED BY THE AMA, AOA, AAFP, (ACGP) ARE ACCEPTABLE.

JANUARY 16TH, 1981
Colorado State Board of Medical Examiners
1525 Sherman Street - Room 132
Denver, Colorado 80203

JUST OFF THE PRESS

A new booklet providing clear, concise non-technical answers to common questions about the eye is now available through the National Society to Prevent Blindness.

Profusely illustrated with full-color photographs and simple drawings,

"INTRODUCTION TO OPHTHALMOLOGY"

explains what ophthalmology is and what an ophthalmologist does. It covers the eye and how it sees, points out some frequent misconceptions about vision, and discusses common eye disorders and how they are dealt with.

The 40-page booklet is ideal for education of nurses and other health professionals, as a reference source for students, for doctors' offices and clinical waiting rooms, for libraries, and for health career programs.

Developed by the Interprofessional Education Committee of the American Academy of Ophthalmology, it is endorsed and distributed by the National Society to Prevent Blindness at an introductory price of \$3.50 a copy.

You can order copies from:

National Society to Prevent Blindness

79 Madison Avenue

New York, N. Y. 10016

(The above announcement is offered in cooperation with the Colorado Society to Prevent Blindness, Inc., 3506 E. 12th Avenue, Denver, Co. 80206.)

CERTIFICATE OF SERVICE AND ROBINS AWARD

The deadline for receipt of nominations for the Colorado Medical Society's CERTIFICATE OF SERVICE award and the ANNUAL ROBINS AWARD is June 1, 1981.

The Certificate of Service is the highest award given by the Colorado Medical Society to a physician for "outstanding contribution to the Constitutional purpose of the Society."

The purpose of the Robins Award is to honor a physician in our state "for outstanding community service."

Send nominations to the Confidential Awards Committee, Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado 80218. These awards will be presented during the Colorado Medical Society's Annual Session, September 8-12, 1981, at Keystone.

Money, Money, Money #2

The Denver Metropolitan Council of Auxillary Presidents presents, BY POPULAR DEMAND, another program specifically designed for medical families concerning personal and medical practice money management.

TOPICS FOR DISCUSSION INCLUDE:

Investment Tips
Current Real Estate Trends
Do's and Don'ts of Insurance
Tax Shelters

THE PANEL OF SPEAKERS:

Shelia Kowal, Stockbroker on
Cindy Fox, Insurance - Real Estate of
Mary Rae, Real Estate

WHEN? SATURDAY, MARCH 14, 1981. WHERE? SHERATON INN, Denver Tech Ctr.
Registration: 9:00 a.m. I-25 & Bellevue (NE Corner)

PROGRAM: 9:30-11:30. LUNCHEON: Noon to 1:30. OPTIONAL TOUR: 1:30-3:30.

COST: \$ 3.50 COST: \$ 9.25 COST: NONE

(NOTE: Carpools will be arranged to and from Denver Tech Center)

MAIL RESERVATIONS BY MARCH 7 to: Susan Kelly, 17 Martin Lane, Englewood, Colorado 80110 (761-5780).

CLIP AND RETURN WITH YOUR CHECK FOR RESERVATION!

NAME: _____ PROGRAM (\$3.50) _____

PHONE # _____ LUNCHEON (\$9.25) _____

☐ I would like a special vegetarian plate, (available at the luncheon price).

Committee Appointments By State Legislature

The Fifty-third General Assembly has begun its work in a slow manner, necessitated by 22 legislators being new to the process. As of the deadline for this article, the Speaker of the House had not released the names of committee chairmen* or members, but the make up of the Senate Committee, with which we deal most, is as follows:

Health, Environment, Welfare & Institutions (HEWI)

Senator William Hughes (R), Colorado Springs, Chairman; Senator Joel Hefley (R), Colorado Springs, Vice Chairman; Senator Polly Baca-Barra-gon (D), Thornton; Senator Cliff Dodge (R), Denver; Senator Martha Ezzard (R), Englewood; Senator Martin Hatcher (D), Gunnison; Senator Harvey Phelps (D), Pueblo; and Senator Ted Strickland (R), Westminster.

Other committee chairmanships went to the following Senators:

Agriculture, Natural Resources & Energy

Senator Yost (R), Crook, Chairman; Senator Clark (R), LaJunta, Vice Chairman.

Appropriations

Senator Stockton (R), Lakewood, Chairman; Senator Durham (R), Colorado Springs, Vice Chairman.

Business Affairs & Labor

Senator Zakhem (R), Denver, Chairman; Senator Clark (R), LaJunta, Vice Chairman.

Education

Senator Meiklejohn (R), Arvada, Chairman; Senator Dodge (R), Denver, Vice Chairman.

Finance

Senator Fowler (R), Boulder, Chairman; Senator Noble (R), Norwood, Vice Chairman.

Judiciary

Senator Paul Powers (R), Denver, Chairman; Senator Ezzard (R), Englewood, Vice Chairman.

Local Government

Senator Barnhill (R), Golden, Chairman; Senator Beatty (R), Fort Collins, Vice Chairman.

State Affairs

Senator Strickland (R), Westminster, Chairman; Senator Ray Powers, Colorado Springs, Vice Chairman.

Transportation

Senator Bishop (R), Grand Junction, Chairman; Senator Yost (R), Crook, Vice Chairman.

One looks at this roster with interest and with hopefully concealed humor, for eight of them are rumored as congressional or gubernatorial hopefuls in the next election. It will be fun to watch the different brands of leadership!

**Late Release:*

The following chairmen of House Committees were announced:

Agriculture, Livestock & Natural Resources

Rep. Younglund (R), New Raymer, Chairman; Rep. Hinman (R), Kremmling, Vice Chairman.

Appropriations

Rep. DeNier (R), Durango, Chairman; Rep. Hume (R), Boulder, Vice Chairman.

Business Affairs & Labor

Rep. Winkler (R), Castle Rock, Chairman; Rep. Minahan (R), Security, Vice Chairman.

Education

Rep. Stephenson (R), Colorado Springs, Chairman; Rep. Spano (R), Arvada, Vice Chairman.

Finance

Rep. Paul Schauer (R), Littleton, Chairman; Rep. Heim (R), Colorado Springs, Vice Chairman.

Game, Fish & Parks

Rep. Scherling (R), Aurora, Chairman; Rep. Gillis (R), Lamar, Vice Chairman.

Judiciary

Rep. Spelts (R), Littleton, Chairman; Rep. Robb (R), Grand Junction, Vice Chairman.

Local Government

Rep. Lillpop (R), Alamosa, Chairman; Rep. Armstrong (R), Grand Junction, Vice Chairman.

Rules

Rep. Randall (R), Colorado Springs, Chairman; Rep. Mielke (R), Lakewood, Vice Chairman.

State Affairs

Rep. DeFilippo (R), Golden, Chairman; Rep. Lee (R), Lakewood, Vice Chairman.

Transportation

Rep. Faatz (R), Denver, Chairman; Rep. Reeves (R), Littleton, Vice Chairman.

WHY?

If you were asked to serve as a member of the Council on Legislation, how would you reply? Most people involved with the Council believe membership on this Council to be an interesting, educational and, sometimes, almost prestigious assignment—that requires much of your time and a lot of hard work.

The Council meets weekly during legislative session with an average of 30 meetings per year. In odd-numbered years the legislature is in session for five or six months. In addition to the time away from one's office, members receive a volume of bills and resource material to review before each Council meeting, and numbers are often asked to testify before legislative committees at the capitol.

Fortunately for CMS, ten physicians replied in the affirmative to this charge, and the past chairman of the Council, Dr. Jack Warren, agreed to remain on the Council as an ex-officio member. Each member was asked "WHY?" You'll be interested in the member responses:

Dr. Jack Klapper

Specialty: Neurology

"Many important items come before the State legislature which directly impact the practice of medicine. I want to insure that there is appropriate input from Colorado physicians into the legislative process."



Dr. Charles Dafoe

Specialty: Ob-Gyn

The Council allows me to have input into the shaping of public opinion and the public's perception of what doctors do to provide total medical care to the American public. It also allows me to educate our legislators as to the realities of delivering the highest quality medical care possible.



Dr. Ben Galloway

Specialty: Pathology

During the past ten years government has significantly increased its role in decision-making affecting health care issues. In many instances, these decisions have isolated those most directly responsible for the delivery of health care from input into the decision-making process.

Therefore, if we care about the future prospects of our profession and the patients we serve, it is imperative that our state medical society become more ef-



fective in influencing the decision-making process, i.e., the Colorado legislature. The success of this effort requires participation by physicians through the state of Colorado.

The importance of physician involvement in this effort has influenced my decision to work actively in furthering our goals to provide high quality health care at responsible costs.

Dr. James Woodward

Specialty: Ophthalmology

"Medical practice" is, ideally and in the final analysis, a doctor/patient relationship. However, the availability and the quality of care depends upon hospitals, other provider facilities, public funds, interaction with non-physician providers and many other factors. Membership on the Colorado Medical Society Council on Legislation has allowed me to have input into these matters.



Dr. H. R. Safford, III

Specialty: Urology

Throughout medical school and residency, I saw the governmental process unfavorably altering the practice of medicine. I felt impotent.

At a Colorado Medical Society required orientation course, I began to realize that there were ways to affect change.

The CMS Legislative Council is the HUB of all activity within the CMS. It is *THE MEANS* by which changes can be affected on a state level by 1) reviewing legislative bills, 2) by personally helping to shape or write these bills, 3) by listening to the CMS lobbyist, 4) by volunteering to testify before legislative committees and, 5) by getting to know legislators individually.

I can effect change in a positive manner through my membership on the CMS Legislative Council. Through this process we (the Council/the physicians) not only protect the interest of the public but we also try to protect the professionalism of the practice of medicine as I view it.

Dr. Jack Warren

Specialty: Psychiatry

Working in the Council on Legislation one learns a lot. It's like trying to drink from a fire hose: Sometimes you get soaked but then sometimes you get a lot to drink.

You learn a lot because you work with a complex collection of lawmakers: administrative, judicial and



legislative. You work on the toughest problems in organized medicine. You work with some of the brightest people in the medical society, from the membership and the staff.

When you get soaked you can try again with a different twist, and when you don't get soaked you can feel the gratification of having learned a lot while doing something important. You also get the help of some of the finest (and sometimes the soggiest) people in the world.

Dr. David Edwards, Chairman Legislative Council
Specialty: Pathology

It is important (if physicians are to have an influence on their future) that they actively participate in their medical societies, particularly in the legislative arena. I feel that it is essential that each of us, at some time in our medical careers, makes a special effort to do his part in the political/legislative sphere.

Dr. Gregory Baron

Specialty: Ophthalmology

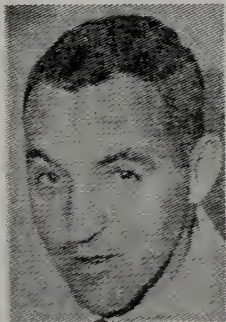
We are all extremely aware of the effects of legislation on organized medicine—and I consider it my duty to provide as much input as possible into responsible health related legislation. This should be the main arena of activity for all physicians interested in preserving the practice of medicine as we now know it.



Dr. James Delaney

Specialty: Ob-Gyn

I was taught that I have an obligation to contribute to the community in some way. Time, talent and money are all needed and I try to make a concerted effort to balance all these with responsibilities to my family and my practice.



Legislative action has the potential to create the greatest impact on our collective societies, and the way our legislative process works enables individuals and special interest groups to have significant impact on the course of legislative action. It is for these reasons that I am delighted to serve on the Council for Legislation of the Colorado Medical Society. I have no special interests or specific legislative action to promote, but I am committed to supporting the private practice fee-for-service tradition.

Dr. Robert Sawyer

Specialty: Surgeon

The biggest impact on the practice of medicine is coming from legislative and regulatory decisions being made by people who know nothing about medicine.

I grew up in a family that believed that people can and should make a difference. Serving on the Council on Legislation gives me one such opportunity.



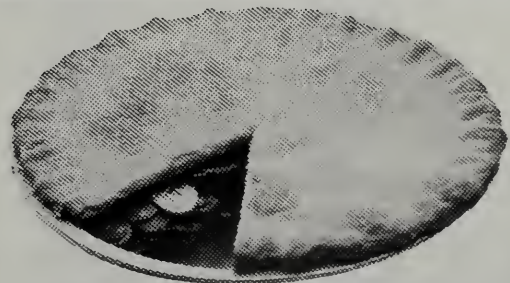
Dr. Theodore Sadler, Jr.

Specialty: Cardiovascular Surg.

Unavailable for comment.



It is understandable that there are many reasons why CMS members are unable to accept an assignment as demanding as membership on the Legislative Council; however, there is an alternative: vow that you will become a regular user of the CMS Legislative Hotline (832-9527). This service not only keeps you informed on health related issues, but at the end of the daily, recorded message, you have the opportunity to inform *your council* of your position on the proposed legislation. Another resource is the weekly lobbyist's report which is mailed to all component society Presidents, society executives and KeyContacts. The Council urges you to also comment directly to the Government Affairs Division staff (861-1221 or the WATS 1-800-332-4150) who will convey your message to the weekly meeting of the Council. Let the Council know where you're coming from—you have nothing to lose, and a great deal to gain!



Photograph by Jan Oswald

When you give the Mile High United Way, 89.46% of your gift goes directly to community organizations that help people. That's a big share of the pie!



Mile High United Way
Thanks to you, it works for all of us.

Physician's Life vs. The Family Unit

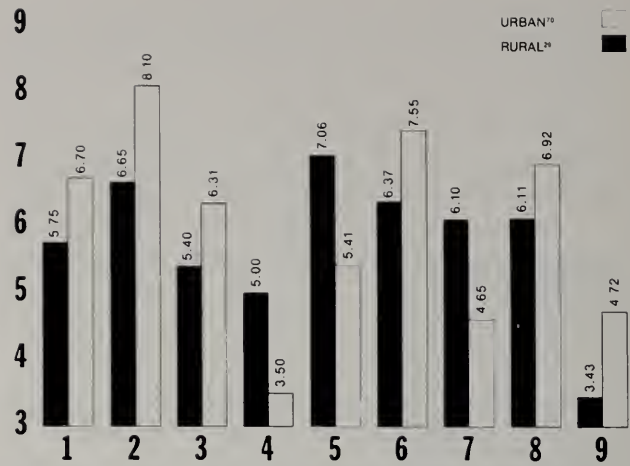
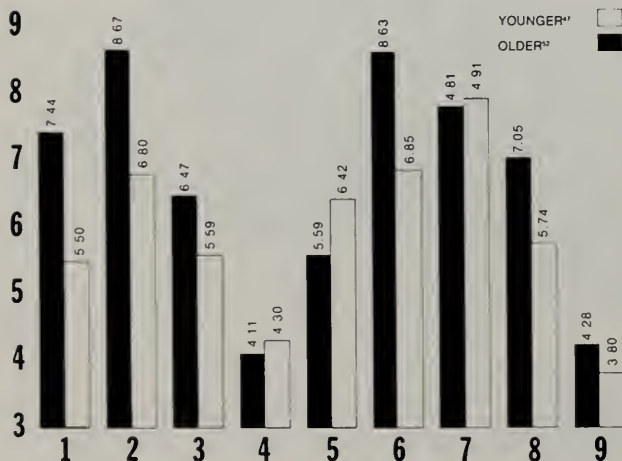
Colorado Medical Society Auxiliary members have found one of the areas of most concern to the physician's family: the effects of the physician's life on the family unit.

During September, 1980, Auxiliary members conducted a rather extensive survey of Colorado physicians and their spouses to determine how the family unit differed from that of persons in other professions and similar socio-economic circumstances. The survey included physicians in both the urban and the rural setting as well as those in relatively new as opposed to long-established practices.

The questions or statements which the respondents were asked to rate are meaningful, and the response indicates that there is a need for solutions to these and other problems of the physician family.

Four graphs include answers from all 99 respondents, who indicated whether they agreed or disagreed with each of the ten statements. In other words, in the "cumulative" graph, on statement #1, on the scale of 1 (totally disagree) to 10 (totally agree), the statement received a 6.4. Statement #2 got a 7.6, while statement #3 received a 6.0 and statement #4 ("Pressure from patients and would-be patients make an enjoyable social life difficult.") was given a 3.96. That same statement earned a consistently negative rating throughout the survey, while statement #6 ("My sex life in the marriage is satisfactory.") received a high 7.5 or 8.0. Physicians in practice longer rated statement #6 higher than those physicians and spouses who had not been in a practice as long.

There are interesting differences in the physician family unit showing up in the urban versus the rural physician, as well as the younger physician as opposed to the physician in practice a longer period of time.



#RETURNED PHYSICIAN 32
SPOUSE 67
TOTAL 99

1. Overall, I believe physician's families have problems no greater than other families of similar socioeconomic status.

2. My marriage has met my expectations.

3. My family usually has adequate time together.

4. Pressures from patients and would-be patients make an enjoyable social life difficult.

5. Children in the family can have difficulties because of the frequent absence of the physician/parent.

6. My sex life in the marriage is satisfactory.

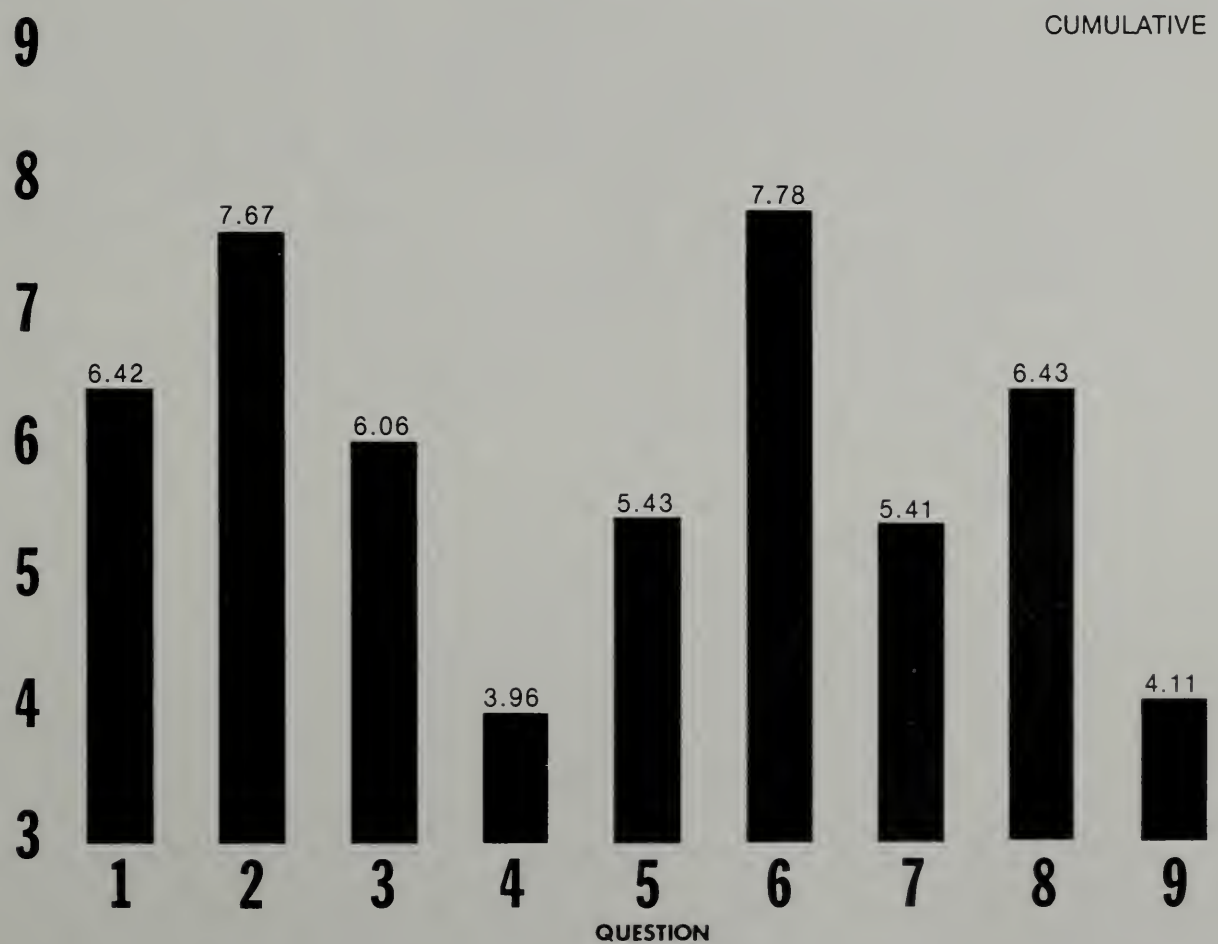
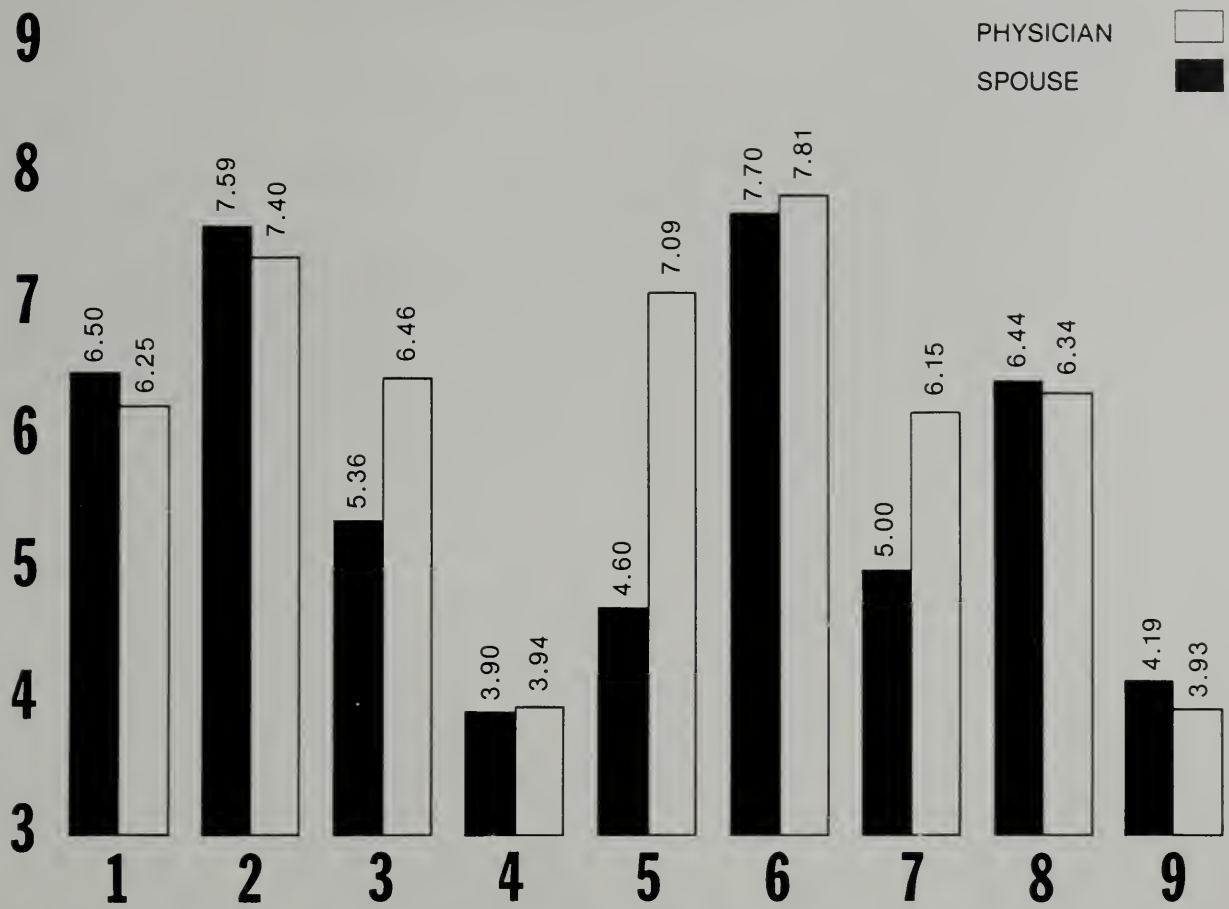
7. Sometimes I feel isolated and alone.

8. If my marriage were deteriorating, it would be easier for me to seek professional help.

9. When the marriage becomes dysfunctional, it is usually the spouse of the physician who is in greater need of psychological help.

1 = TOTALLY DISAGREE

10 = TOTALLY AGREE



**When painful spasm
is the presenting
symptom...**



Single Entity Bentyl[®]

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets, 10 mg./5 ml. syrup, 10 mg./ml. injection

On target for the functional bowel/irritable bowel syndrome*

Single entity means

- ⊕ a variety of Bentyl dosage forms (tablets, capsules, syrup, injectable) that lets you tailor the dose to your patient's primary need
- ⊕ freedom to choose and titrate concomitant medication when a psychogenic disorder coexists

On target means

- ⊕ bioequivalence of oral dosage forms that permits patient's choice—fosters patients' compliance
- ⊕ bioavailability of all dosage forms that encourages therapeutic effect
- ⊕ significant pharmacologic activity that can be demonstrated at the target site in the distal colon (Figure 1)

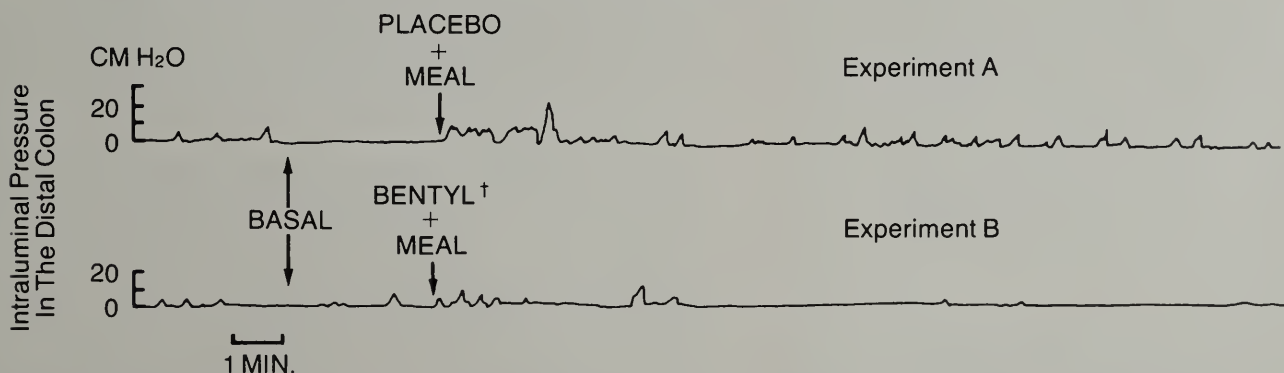


Fig. 1. In this irritable colon patient, the motility index for the colonic wave pattern shown in A, following a meal and intramuscular placebo, was calculated at 86 ± 28 . On a separate day, the motility index for the colonic wave pattern seen in B, following a meal plus intramuscular Bentyl, was calculated at 14 ± 8 . The decrease in motor activity induced by Bentyl was statistically significant ($p < 0.05$), in spite of the wide range of the standard error of the mean.

from a Study by A. R. Chowdhury
and S.H. Lorber, 1980

*This drug has been classified "probably" effective for this indication.

†Although the dose of Bentyl used to show pharmacologic effect was 50 mg., which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg. dose. Presumably, the same pharmacologic effect, as shown in Figure 1, would follow. These observations do not constitute evidence of efficacy.

Merrell

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION
Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

0-6545 (Y080C) MNQ443

Colorado Begins Innovative Drug Program: Channel One

DENVER—Five Colorado communities have been selected for an innovative drug prevention program called Channel One, in which youth help themselves by helping their communities, according to the Colorado Department of Health.

The National Institute of Drug Abuse provided the Health Department with \$50,000 for the five sites which include Alamosa, Durango, Colorado Springs, Pueblo and Trinidad. Each community will receive up to \$1,000 to plan its project and \$9,000 to implement it.

Each community has a planning committee which includes a community agency representative, business representative, local citizens and the youths. The committee will develop a project which best meets the community's needs and the youth will then carry out the project. Examples are cleaning up parks, renovating a community center or setting up a youth-owned business or theatre group.

Fred Garcia, state prevention coordinator from the Health Department's Alcohol and Drug Abuse Division, said the local drug prevention program selects youths from ages 10 to 16 who are considered to be a risk of becoming drug abusers.

By becoming involved in the projects, the youths earn salaries and gain marketable skills, experience, confidence and satisfaction, he said.

Garcia will work closely with each site as a consultant and project officer. Implemented for the first time in Colorado this year, Channel One projects have been conducted very successfully in other states, he said.

The lead prevention programs and business partners from each of the five sites are:

Alamosa: Prevention Concepts Inc. and Sociedad Protection Mutua de Trabajadores Unidos.

Durango: Youth Advocates, Inc. and Great Scot Timber and Logging.

Colorado Springs: Urban League of Pikes Peak and Digital Equipment Corporation.

Pueblo: Pueblo Youth Services Bureau and Latino Chamber of Commerce.

Trinidad: City of Trinidad and Jaycees.

Ski Injury Analyzed

Skiers were interested in a study which found that their new-type runaway straps (holding ski to boot in event of a fall) actually were causing the ski tips to fly up and hit the skier in the face. Switching to a simple braking device could correct the problem.

Physicians May Prevent Utility Shutoff

During the winter months, many Colorado low-income families experience the possibility of utility discontinuation. Physicians have the opportunity to refer a person in need to the LEAP program, or to help them obtain medical certification necessary to prevent a shutoff.

The new low income energy assistance program is available to these families to help them pay their heating costs. Applications are available through county departments of social services; or, interested persons may call the LEAP hotlines: 1-800-332-6730 or 839-2885 (Denver).

In addition, the Public Utilities Commission has passed procedures which must be followed by utilities when attempting to shut off utilities. Under Revised Colorado Public Utilities Commission "Rule 13", a delinquent customer's service may not be disconnected if a licensed physician certifies in writing that "... termination of service would aggravate an existing medical condition or create a medical emergency for the customer or a permanent resident of the customer's household." Such certification prevents disconnect for sixty days with a thirty day extension possible. Therefore you, as a physician, may have the opportunity to refer a person in need to the LEAP program or to help them obtain the medical certification necessary to prevent a shutoff.

A host of medical advice for joggers continued to appear in the medical journals and in the public press. A Canadian researcher offered pointers for avoiding heat stroke while jogging—take plenty of fluids, run in the early morning or evening on hot days, slow down speeds in hot weather.

Colorado Health Study Absolves Ski Areas

DENVER—Winter visitors to three Colorado ski resorts in February and March 1980 did not develop giardiasis, according to a Colorado Department of Health study released by Dr. Richard Hopkins, chief of the Communicable Disease Control Section.

Giardiasis, a diarrheal illness, has been rumored to be evident in mountain resort areas resulting from drinking the water. The Health Department began the study earlier this year to evaluate that risk, testing more than 500 physicians and family members.

Of 343 tested before and after their visits, none acquired giardia between the two tests. Five had giar-

(Continued on page 42)

Drug Therapy Questions and Answers

Christopher S. Conner, Pharm.D., Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; Dennis R. Sawyer, Pharm.D., Associate Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; and Earl Sutherland, M.D., Ph.D., Medical Director, Rocky Mountain Drug Consultation Center, Attending Physician, Denver General Physician, Denver General Hospital, Assistant Professor of Medicine, University of Colorado School of Medicine.

This bimonthly column is designed to provide Colorado physicians with specific answers to commonly asked questions regarding drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column were generated from calls received by the Rocky Mountain Drug Consultation Center from physicians and other health professionals.

HETASTARCH (HYDROXYETHYL STARCH): USE AS A PLASMA EXPANDER

Request:

How effective is hetastarch as a plasma expander? Are there any studies comparing it to albumin?

Response:

Hydroxyethyl starch (hetastarch) has been used for several years in Great Britain and other countries as a plasma expander. Hetastarch 6% has recently been released in the United States by McGaw Laboratories as Volex, and by American Critical Care as Hespan®. Each contains 6 gm hetastarch per 100 ml normal saline in 500 ml IV infusion bottles (Prod. Info., 1980 A & B). Hetastarch 6% reportedly has colloidal properties similar to those of human albumin and IV infusion results in expansion of plasma volume slightly in excess of the volume infused, which reportedly improves hemodynamic status for at least 24 hours (Prod. Info., 1980 A). Hetastarch has a molecular weight of about 450,000 (Prod. Info., 1980 A & B) and supposedly persists longer in blood than other plasma substances, usually for approximately 2 weeks (Anon., 1971). Hetastarch is prepared from waxy sorghum starch (an amylopectin) by treating the starch with sodium hydroxide and ethylene oxide until 90% of the glucose units have reacted. Most of the hydroxyethyl groups are attached to the C-6 position of glucose units. It is re-

(Continued on page 41)

practice management

Question:

Federal Income Taxation: Can I deduct the difference between my charge to, and the payment from, Medicaid?

Answer:

Not currently, unless you are willing to provide a test case for the taxman.

Reasons:

Federal law allows you to deduct *ordinary and necessary business expenses* from your gross income to arrive at *adjusted gross income*. It also permits you to deduct *bad debts* for this computation.

Federal law allows you to deduct certain taxes from adjusted gross income.

Your subsidization of the Medicaid program is not an expense because each time you submit a bill you agree that payment received is payment in full. Therefore, by contract you are denied the use of this deduction.

That is not to say you cannot deduct the cost of tongue depressors or dispensible surgical trays. They are commodities which you have paid for and use in the ordinary and necessary course of your business.

Because you have agreed to accept Medicaid payments as payment in full (see the back of your billing form), no legal debt is created. Therefore, the bad debt deduction is unavailable.

Even if the statement above were not true accounting systems generally used by physicians would not permit a bad debt deduction. Physicians use cash accounting which reflects monies actually received as gross income. If a certain amount is not received, it cannot be used as a deduction from in-

come because it has not been reported as income. Example: Dr. Jones charges \$10.00 for a service. Patient pays \$7.00. Dr. Jones' accounting system reports \$7.00 as income, not \$10.00. There is no \$3.00 deduction permitted. Conversely, if Dr. Jones' accounting system reports on an accrual basis, \$10.00 is designated as income. The \$3.00 debt is then a permitted deduction.

Finally, is your subsidization of the Medicaid program a tax? Five basic tax payments are deductible:

1. Taxes on real property (home, office),
2. Taxes on personal property (automobile),
3. Sales taxes,
4. Income and excess profits taxes, and
5. Windfall profit taxes.

None of the above specifically relate to a safe deduction. Always check with your accountant before you venture into unknown tax territory.

Bureau of Labor Statistics

Have you been contacted by the Bureau of Labor Statistics for economic data which may be used to construct a physician services index in Colorado? If you have, please contact Robert M. FitzGerald at the Colorado Medical Society.

The Colorado Medical Society proudly presents Conomikes Associates, Inc. as seminar consultants in the area of practice management. Several sites will be visited *throughout the week of May 4, 1981*: Durango, Pueblo, Denver, Greeley and perhaps Grand Junction.

Three one-half days seminars will be presented at each site (building and room locations are not yet finalized):

1. Financial control (physicians only),
2. Billing—collections—insurance
3. Reception Areas—patient flow.

Each seminar requires a tuition of \$55.00. Please pay by check, and contact Robert M. FitzGerald at the Colorado Medical Society. Courses will be closed upon the paid enrollment of 50 persons.

Cost Containment and the Physicians Service Index

All services
Hospital room
Physicians' services

| 1980 | | | | | | | | | | | |
|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---|
| J | F | M | A | M | J | J | A | S | O | N | D |
| 1.5 | 1.5 | 1.8 | 1.5 | 1.5 | 1.9 | -.7 | .0 | .8 | .00 | .11 | * |
| 1.5 | 2.0 | .6 | .5 | .5 | .6 | 1.4 | 1.4 | 1.0 | 1.7 | 1.2 | * |
| 1.4 | 1.6 | .8 | 1.0 | 1.0 | .6 | .6 | .5 | .7 | .7 | .7 | * |

*December figures unavailable at press time.

Congratulations on your efforts to hold the line on costs. Physicians are doing the job the CMS House of Delegates supports.

The figures below represent figures the AMA received from the Bureau of Labor Statistics. All figures are seasonally unadjusted.

Total Joint Replacement Arthroplasty

*Review of Current Literature**

Bernard C. Sherbok, MD, Denver, Colorado

Total joint replacement may be defined as the removal of cartilage from both sides of a joint and replacement with either plastic or metal. This operation is one of the most outstanding contributions to orthopaedic surgery in many decades. Because the vast majority of patients who undergo total joint replacement have rheumatoid arthritis or osteoarthritis, it should be of interest to medical doctors to have some knowledge of the results currently obtainable by this operation. The purpose of this paper is to deal briefly with the present results of all joints which are replaceable.

Three types of prostheses are utilized: (1) the constrained type which is a self-stabilizing prosthetic replacement, (2) a semi-constrained device which provides some inherent stability such as snap-lock fit or toggle effect, and (3) an unconstrained prosthesis which involves resurfacing the articular cartilage. This prosthesis has little, if any built-in support and must depend on the joint capsule, ligaments and muscles to maintain stability.

Indications and Contraindications

Three categories of advanced joint disease account for the majority of all replacement operations, namely rheumatoid arthritis, osteoarthritis and degenerative arthritis due to trauma. These diseases have certain predominant symptoms in common: severe pain, limitation of motion, disability and deformity. Regardless of the joint, these symptoms are indications for surgery. The goals of joint replacement are to obliterate pain, to increase motion, and to decrease disability. There are also specific contraindications such as active infection, neurotrophic joint disease and pronounced spasticity or paresis of muscles about the joint.

Hip Joint

Since the hip joint was the first to be replaced totally, it is logical to start with the analysis of the present results. Anatomically the hip is the most ideal for total replacement surgery because it is a ball and socket joint. The operation has been performed for a sufficient number of years so that the present results of many authors are accurate and predictable. One must understand that there are many different types of prostheses available; in addition, the surgeon's skill must also be considered. The average good and excellent results comprise about 95 percent of all cases. For example, Cupric¹ reported a review of 409 cases of replacement arthroplasties with only 3 late failures. The excellent results have been fully maintained for as long as 14 years.

In spite of glowing reports, one must always keep in mind that, if failure occurs, revision surgery can be very serious. Moreover, long range complications such as loosening either of the prosthesis, bone cement or both are now appearing in the literature. A ten year followup of cases by Harris² shows evidence of demarcation between cement and bone on the acetabular side in 70 percent of the cases and that nine percent of the sockets had become grossly loose. This author stated that "loosening due to cement failure is truly our number one problem in total hip replacement." Charnley³ recorded a 15 year follow-up of his cases; 25 percent of the acetabular components showed loosening radiographically. Postoperative infection which in a series of 3,590 cases reported by Salvati⁴ was a serious problem between the years 1967 and 1969 with a rate of 13 percent. Subsequently, the rate dropped to 2 percent by using prophylactic antibiotics and an air-flow system.

Thromboembolic disease is now the most frequent complication in total hip replacement. Harris⁵ states, "There cannot be much doubt of the magnitude of the problem. In studies we have done in world literature, we have found that deep thrombosis occurs in about 50 percent of the cases. Pulmonary emboli occur in about 10 per-

*Presented at a Medical Conference, Zhong Shan Medical College, Canton, China, September 12, 1980.

cent and fatal emboli in about 2 percent. He recommends the use of aspirin for men and coumadin or dextran for women as a preventative.

At present in cases of severe bilateral hip involvement some orthopaedic surgeons are following the lead of Jaffe and Charnley⁶ who in 1971 reported a series of 50 bilateral cases in which a single procedure was utilized. They claimed that with the one-step operation there were fewer complications and a more rapid post-operative recovery. This conclusion has been verified by other authors including Salvati⁷.

Knee Joint

The knee joint presents an entirely different challenge. It is a ginglymus or hinge joint anatomically, the stability of which depends upon ligaments and muscles. Several different types of prostheses, both constrained and unconstrained, have been tried.

The present results are not quite as good as for the hip joint. VanHegan, Dabrowski, and Arden⁸ reported their series of 100 cases which had a 4 year follow-up. Pain was relieved in 85 percent; 77 percent had a useful range of motion with a stable knee. Gibbs, Green and Taylor⁹ recorded their results of 75 cases. Eighty percent were successful of which 33.8 percent were rated as excellent. There were 20 percent failures but no disasters. Peterson, Fitzgerald and Johnson's¹⁰ results of their analysis of cases followed 5 years or longer showed 88 percent had no or minimal pain and an average range of motion of 98°. Eighty-seven percent of the patients were satisfied with the operative result. This series comprised those cases in which an unconstrained prosthesis was used. A prior series using a constrained device revealed a major complication rate of 20 percent. Hopson *et al*¹¹ evaluated 109 geometric total knee replacements performed from 1972 to 1977. Eighty-two percent of the osteoarthritic knees but only 68 percent of the rheumatoid joints were rated good to excellent. Their overall failure rate was 10 percent. The rate of component loosening was 2.8 percent. There were no infections. One of the conclusions was "The multiplicity of designs available at present, however, attests to the fact that the final solution to the problem of total knee replacement has not, as yet, been found."

Some orthopaedic surgeons are performing bilateral knee procedures at one operation. Volz¹² claims the advantages are the requirement of only one anaesthetic, reduction of operating

room risk and slightly less operating time per knee, 80 minutes as compared to 96 minutes in the single knee group. The average hospital stay in bilateral cases was 31 days and 18 days in the unilateral. It is obvious that the ability to perform bilateral surgery at one operation depends upon the skill of the operator, the ability of the entire surgical crew and the availability of the necessary equipment.

Ankle Joint

Total replacement of the ankle joint presents challenges which differ from the other major joints of the lower extremity. It is a ginglymus joint, the stability of which depends on the integrity of the malleoli and the ligaments. Total ankle arthroplasty has lagged behind the hip and knee mainly because arthrodesis has been a rather successful procedure.

Unlike the hip and knee joints, the ankle is rarely the site of osteoarthritis. In addition to the general indications, this operation may also be performed in certain cases of pseudoarthrosis resulting from attempted arthrodesis and avascular necrosis of the talus. The prosthesis used is the conjoined or hinged type.

Demohaz, Mazur, Thomas, Sledge, and Simon¹³ related their experience with 21 replacements in 19 patients. The average followup period was 14.7 months. They stated that "The relief of pain and functional improvements were disappointing." Followup statistics indicated only 19 percent were relieved of pain; 88 percent had increasing radiolucent lines and 10 percent had late loosening of the prosthesis. The authors make a special point; this operation should only be used in elderly patients.

Newton's series¹⁴ of 50 cases comprised 34 with posttraumatic degenerative disease, 10 with rheumatic arthritis, 3 cases each of avascular necrosis of the talus and pseudoarthrosis following attempted fusion. There were ten failures out of 34 with posttraumatic degenerative disease. The 24, however, were "extremely happy with their ankles". Of the 6 out of 10 patients with rheumatoid arthritis who had long term prednisone, 5 were failures. Four patients not on prednisone were satisfied with their results in 3 instances. Two of the 3 cases of avascular necrosis of the talus were failures.

Dini and Bassett¹⁵ operated on 21 patients between 1974 and 1977. Good results were obtained in 8 who had posttraumatic arthritis and 2 with

rheumatoid arthritis. Postoperative relief of pain in 16 cases was good in 8, fair in 4 and poor in 4. Stauffer's¹⁶ experience in 94 cases was somewhat more optimistic; 72.5 percent were satisfactory (excellent and good) and 27.5 percent were unsatisfactory (fair plus poor). Ninety percent ultimately had relief of most of the pain but only 55 percent had any increase in motion, the average being 7 percent. Of the patients who had rheumatoid arthritis, 88 percent had satisfactory results. Sixty-one percent of posttraumatic cases were satisfactory. Seventy-seven percent of patients older than 60 years had satisfactory results. Younger more active individuals had more disappointing results.

First Metatarso-Phalangeal Joint

The only joint in the foot which is suitable for total replacement is the first metatarso-phalangeal joint. This joint is subject to painful osteoarthritis, rheumatoid arthritis, hallux valgus and hallux rigidus. In addition, this procedure has been used in unsuccessful operated cases of hallux valgus and traumatic arthritis. The indications for surgery are pain, deformity and disability.

Swanson, Lumsden II and Swanson¹⁷ had experience both with single and double stem flexible hinge silicone implants. These implants were "rewarding, simple and safe". The latter prosthesis was more satisfactory in rheumatoid arthritis and in advanced cases of hallux valgus in the elderly. Preoperative pain and inability to wear a shoe were relieved in a great majority. Good to excellent results with hinged silicone implants were also attained by Cracchiolo¹⁸ who reviewed 52 patients who had undergone 81 operations of which 29 were bilateral. Most of the patients had rheumatoid arthritis although many had osteoarthritis. The author also used this type of implant in other MP joints. Walking was significantly improved in 63 percent but only 30 percent had definite improvement in function. Pain was relieved and most patients were able to wear stylish shoes.

Total Joint Replacement of the Upper Extremity

The joints of the upper extremity are relatively complex, especially the elbow, and therefore present somewhat different challenges than the lower extremity. Loss of motion and instability are

secondary indications for replacement. Primary osteoarthritis is not encountered very often in the upper extremity.

Shoulder Joint

Cofield's¹⁹ results showed that 92 percent had mild or no pain and very satisfactory improvement in such functions as tending to personal hygiene (96 percent), ability to comb hair (71 percent), the use of eating utensils (96 percent), and the use of the hand for light work (71 percent). In Averill's²⁰ series over 90 percent of 54 patients had improved both in active flexion and abduction of more than 50° associated with increased strength. Post, Haskell and Jablon²¹ used a constrained type of prosthesis in 42 patients. There were 12 material failures in their first series of 22 cases and only 2 out of 21 in the second series. Relief of pain in the first series was excellent in 8, good in 2 and poor in 1. These figures respectively in the second series were increased to 13, good in 2 and fair in 2. Overall improvement in active function was 83.5 percent in the first series and 89.6 percent in the second. In Cofield's²² series of 23 patients, pain relief was satisfactory but 6 reoperations were necessary. Motion greater than 90° was rarely achieved. He sounded a cautionary note; namely, patients selected for this operation must have significant disability due primarily to pain. Only when fusion is indicated should a prosthetic arthroplasty be considered.

Total Replacement of the Elbow Joint

The elbow joint is complex anatomically and therefore is very difficult to replace with a prosthesis. The indications are similar to other joints. Kudo, Iwano and Watanabe²³ operated 24 rheumatoid arthritic elbows, using an unconstrained prosthesis. The average follow-up period was 3 years and 10 months. Excellent results were obtained in 14 (58 percent), fair in 7 (29 percent), and poor in 3 (12.5 percent). Stability was good in all but 1. Two elbows did not regain a useful range of motion. Morrey and Bryan²⁴ operated on 88 patients in all, but 15 had rheumatoid arthritis. Fifty-two per cent had good results, 24 percent had fair and 24 percent were poor or failures. The revision rate was 14 percent. The incidence of loosening of the prosthesis was 15 percent. They concluded that elbows which can be reconstructed by more conservative procedures should be so treated.

Total Replacement of the Wrist

Total arthroplasty of the wrist is not performed as frequently as other joints because arthrodesis yields such satisfactory results. One must use experienced judgment before deciding on performing a replacement arthroplasty instead of an arthrodesis unless there is a special need for motion even though at present the replacement procedure is satisfactory. The primary indication is advanced bilateral rheumatoid arthritis.

Beckenbaugh²⁵ claimed excellent relief of pain in 96 percent; the range of motion was 50 percent of normal. However, 85 percent of the patients felt they were significantly improved. Even in successful cases, the patient must be informed that one cannot perform activities such as golf or lift more than 10 pounds.

Total Arthroplasty of the Hand

The trapezio-metacarpal joint (the joint at the base of the thumb) can be replaced. In addition to the usual indications, marked instability of the joint with loss of joint surfaces is an important indication. Braun²⁶ operated on 21 patients over a

period of 5 years. He concluded that relief of pain was remarkable, the range of motion improved, stability was increased and pinch power was restored. In a series by Caffiniere and Aucouturier²⁷ the followup period ranged from 6 months to 5 years (average 2 years). Eight out of the 10 had relief of pain, stability was increased in 7 out of 10 and mobility in 6. Five loosening occurred in those cases followed longer than 6 months.

Beckenbaugh²⁸ has done total replacement operations in MP and PIP joints with excellent relief of pain and initial good stability. Motion, however, was only 50 percent of normal. Linscheid and Dobyns²⁹ found that serious flexion contractures can develop when a metallic prosthetic is used. Replacement with a silicone device seems to cause a progressive loss of motion.

Conclusion

In recent years the results of total joint replacement arthroplasty are generally good to excellent. However, the inherent limitations of this operation must be well-understood by both patient and the physician. ●

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Drug Therapy (Continued from page 35)

ported that no short chain length fragments crystallize from solution on prolonged storage (Ricketts, 1973).

Metcalf *et al* (1970) evaluated the physiological effects of hetastarch in 36 preoperative and postoperative patients. Hetastarch 6% was administered by IV infusion over a period of one hour (500 ml in 20 patients, 1000 ml in 16 patients). An average volume expansion of 660 ml was reported over a period of 6 hours with plasma volume returning to original levels by 72 hours. Ten minutes following IV infusion, 84% of hetastarch was available in the circulation, with approximately 6% being excreted. At 72 hours, 22% was available in the circulation, with 51% being excreted and 27% being unaccounted for. Serum concentrations of 13.5, 7.2 and 4.5 mg/ml were reported immediately following infusion, at 24 hours and 72 hours, respectively. The rate of excretion of hetastarch was 5.6 gm/hr during IV infusion, which decreased to 0.36 gm/hr 12-24 hours later. Sedimentation rate was reported to increase following infusion with white blood cell count decreasing initially and returning to normal within 72 hours. Side effects were minimal, with chills, headache, elevation of temperature, pulse and blood pressure reported in 2 patients and patchy urticaria in 2 others. This study suggested that hetastarch is comparable to dextran physiologically and provides immediate volume expansion which was maintained over a period of 24 hours.

Clinical studies evaluating the efficacy of hetastarch are few, especially comparative studies with dextran or albumin. Ballinger *et al* (1966) administered hetastarch to 15 patients with hypovolemic shock and found it to be an effective plasma expander, comparable to dextran 75. Gollub *et al* (1969) administered 250-500 ml hetastarch 6% IV (over 30 min) to 26 patients during surgical procedures (operation without extracorporeal circulation, during cardiopulmonary bypass, immediately following extensive surgery). Blood pressure, pulse rate, respirations and urinary output did not change significantly. Blood volume increased in all patients which exceeded the amount of hetastarch administered. A minor transient bleeding diathesis was reported in one patient.

Solanke *et al* (1971) evaluated the plasma expanding effects of dextran-70, hetastarch 6%, plasma and a commercial gelatin derivative (Haemaccel®). Plasma volume expansion was measured by the dye-dilution technique, utilizing T-1824 (Evans blue) as a tracer. The adjusted mean plasma volume expansion observed with Haemaccel®, dextran-70 and plasma were similar and approximated the volume infused (645 ml, 580 ml and 718 ml, respectively). Plasma volume expansion with hetastarch 6% was 1108.7 ml, more than twice the amount infused (500 ml over 20-43 min). No adverse reactions were

reported during administration.

Lazrove *et al* (1980) compared the hemodynamic, plasma volume and oxygen transport response of 5% albumin and 6% hetastarch in hypovolemic postoperative patients using a prospective randomized crossover design. Patients were admitted to the study based upon a blood volume deficit measured by the radioactive iodinated human serum albumin dilution method. Ten acutely ill postoperative patients were selected. When patients were considered to be hemodynamically stable, they were randomly administered either 500 ml or 5% albumin or 500 of 6% hetastarch over a period of 60 minutes. Within a 24 hour period, patients were crossed over to receive the other infusion over a period of 60 minutes, in random design. Both 6% hetastarch and 5% albumin produced a significant improvement in plasma volume and flow and small transient increases in arterial and venous pressure, urine output, colloidal osmotic pressure and oxygen transport. No complications occurred during therapy with either hetastarch or albumin, including pulmonary edema, capillary leak, respiratory distress, or shock lung. No allergic reactions or bleeding problems were observed in any patient. The authors conclude that 6% hetastarch is a safe, inexpensive and effective plasma expander, with hemodynamic properties similar to other colloids.

Adverse reactions have not been a major problem during hetastarch therapy. Isolated cases of vomiting, temperature elevation, headache, chills, itching, influenza-like symptoms, peripheral edema and muscle pains have been reported (Prod. Info., 1980 B; Metcalf *et al*, 1970). Anaphylactoid reactions have been reported, but the incidence is low. Ring and Messmer (1977) reported 14 anaphylactoid-type reactions during 16,405 infusions of hetastarch (0.085%) as compared to an incidence of 0.011% with albumin. Serum amylase elevations have been reported, but were not associated with pancreatitis (Kohler *et al*, 1977). Moderate infusions of hetastarch (1500 ml or 20 ml/kg) have not been associated with significant effects on coagulation, however, the effects of larger infusions have not been adequately studied (Prod. Info., 1980 B).

The recommended dose of hetastarch according to the manufacturer is 500-1000 ml, with total dosage not to exceed 1500 ml/day or approximately 20 ml/kg/day. In acute hemorrhagic shock, administration rates approaching 20 ml/kg/hr may be given (Prod. Info., 1980 A & B).

Conclusion

Hetastarch 6% appears to be an effective plasma expander, with available studies suggesting it is as effective as albumin and dextran. Although less expensive than albumin, more extensive data is required to evaluate the effects of persistent serum

(Continued on next page)

(Continued from previous page)

(and tissue) concentrations and the effects of large doses on platelet function and bleeding before hetastarch can be recommended as a routine substitute for albumin.

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Colorado Health Study (Continued from page 35)

dia on both the first and second tests and are presumed to be long-term carriers, according to the study.

Eleven percent of those tested did develop diarrheal illness, with symptoms of gas, cramps and fatigue, which could easily be confused with giardiasis, said Dr. Hopkins.

The physicians drank water almost exclusively from the Vail Water and Sanitation District (town of Vail) and from the Aspen and Snowmass town supplies.

The report could find no correlation with age, sex, race, permanent residence, previous visits to Colorado, number of restaurants visited, ski areas used or amount of water consumed.

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FEBRUARY 1981

15th-20th

THE ROCKY MOUNTAIN PEDIATRIC RADIOLOGY SEMINAR. Vail. Contact: Director of Professional Education, Rocky Mountain Poison Center, West 8th Ave. & Cherokee St., Denver, CO 80204. 893-7774. (20 hours of AMA Category 1 credit).

18th

REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE. Department of Radiology, University Hospital, Denver, CO 80262. Contact: Suzanne Warner, 394-7773. (3 hours of AMA Category 1 credit).

19th

MOST COMMON ALLERGY ERRORS AND HOW TO CORRECT THEM. Vail. Contact: Martin J. Rubino-witz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver, CO 80203.

21st-28th

NEUROLOGY IN OFFICE PRACTICE. Aspen Square Meeting Room, Aspen. Contact: Barry S. Ramer, 2217 Webster Street, San Francisco, CA 94115. (415) 921-0690. (15 prescribed hours of AAFP credit).

21st-28th

11TH ANNUAL ASPEN RADIOLOGY CONFERENCE. Aspen Institute for Humanistic Studies. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

21st-28th

2ND ANNUAL VAIL PATHOLOGY CONFERENCE. Kiandra-Talisman Lodge, Vail. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

21st-28th

20TH ANNUAL MEETING OF THE CANADIAN-AMERICAN MENTAL DENTAL ASSOCIATION. The Mark, Vail. Contact: Jacques M. Quen, M.D., 1385 York Avenue, Suite 17G, New York, NY 10021. (22½ hours of AAFP credit).

22nd-28th

CLINICAL CARDIOVASCULAR DISEASE UPDATE AND BOARD REVIEW. The Mark, Vail. Contact: Department of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068. (312) 698-2200. (31 hours of AMA Category 1 credit).

23rd-27th

PEDIATRIC HEMATOLOGY-ONCOLOGY-IMMUNOLOGY. Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

23rd-28th

FAMILY PRACTICE REVIEW. Denver. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

24th-28th

BEDSIDE APPROACH TO CARDIAC DIAGNOSIS. Keystone. Contact: Dorothy M. Bailey, Office of Education, Rose Medical Center, 4567 E. 9th Ave., Denver 80220. 320-2102. (Category 1 credit and AAFP prescribed credit offered).

26th-28th

MOUNTAIN MEDICINE CONFERENCE. Ouray. Contact: Barry Harper, M.D., Western Colorado Area Health Education Center. 244-2187.

28th-March 7

4TH ANNUAL VAIL CANCER TREATMENT CONFERENCE. Kiandra-Talisman Lodge, Vail. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

28th-March 7

3RD ANNUAL VAIL SPORTS MEDICINE CONFERENCE. Lion Square Lodge, Vail. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, CO 80211. (303) 629-5333 or (800) 525-5810. (22 hours of AMA Category 1 credit; 22 prescribed hours of AAFP credit).

28th-March 7

RADIOLOGY FOR THE NON-RADIOLOGIST. Kiandra-Talisman Lodge, Vail. Contact: Barry S. Ramer, 2217 Webster Street, San Francisco, CA 94115. (415) 921-0690. (15 prescribed hours of AAFP credit).

MARCH, 1981

3rd-6th

EMERGENCY MEDICINE TRAUMA. Tamarron Conference Center, Durango. Contact: Glen E. Garrison, M.D., Director of Continuing Education, Medical College of Georgia, Augusta, Georgia 30912. (17 prescribed hours of AAFP credit).

ROGER D. HAMSTRA, MD, 3-19-34 to 1-20-81

It is with a sincere feeling of personal and professional loss that I report the death of Dr. Roger Hamstra, Associate Professor of Medicine and Director of the School of Medical Technology, University of Colorado. Dr. Hamstra died in a tragic air crash in the State of Washington on Monday, January 20, 1981. The Colorado Medical Society extends its deepest sympathies to Mrs. Joan Hamstra and to the children, Scott, Margot and Kent.

Dr. Hamstra was not a member of the Colorado Medical Society but was well known to the CMS membership and the medical community in Colorado for his continued efforts in public medical education. Roger Hamstra was the long-time host of the award-winning television program, "MEDICALINE," aired once each month on KMGH-TV in Denver. "MEDICALINE" has been a cooperative effort between the University of Colorado School of Medicine, KMGH-TV, the Denver and Colorado Medical Societies for over 6 years.

In 1980, "MEDICALINE" was awarded the Certificate of Merit by the Colorado Broadcasters Association in the category of public service programs. Ironically, on the date of Roger's death the American Medical Association announced that "MEDICALINE" received the Gold Award in Category IV of the AMA National Awards Program for Medical Speakers. The AMA award will be presented, posthumously, during the AMA Leadership Conference in mid-February. "MEDICALINE" was pitted against the top public service and documentary programs and producers in the United States, and the award judges made their decision well before the tragic crash occurred.

Sufficeth to say, Roger Hamstra will be sorely missed by his family, friends and his associates in the medical community. Dr. Hamstra's loss is one of a public nature as well: Roger attended Calvin College and Northwestern University Medical School at Chicago. He returned to Grand Rapids, Michigan, his birthplace, for internship and subsequently moved to Denver for specialty training. He remained at the University of Colorado from that time. Roger's interests extended far beyond his medical practice and teaching; besides a very sincere and abiding interest in his family he was active in his church, The Third Christian Reformed Church of Denver, serving as an elder and teacher in the church school, as a long-term member of the men's church choir, as coach of the church's softball team and he was active in Christian education as a school board member.

Roger Hamstra devoted much of his effort to the betterment of others and to the goal of understanding in all areas. He was an excellent communicator; though we have lost the person, Roger's personification will be present through his lasting accomplishments and contributions.

The program, "MEDICALINE," will continue in its present format and image. The program is broadcast on Saturdays, 6:00 to 6:30 p.m.

Bill Pierson
Director of Communications
Colorado Medical Society

PHYSICIAN'S DIRECTORY NOW BEING DELIVERED!

During the first two weeks of February, all members of CMS should have received their new Physician's Directory. The majority of these books have been handled through the U. S. Mail, while many in the metropolitan Denver area have been hand-delivered.

If you have had no Directory delivery, or if there is some mixup on those Directories which have been delivered, you'll have to contact the Communications Office, CMS, and ask for Bonnie Van Fleet. (861-1221, ext. 245) We'll check the delivery records to see what went astray.

WHEN YOU DO RECEIVE THIS DIRECTORY, PLEASE read the introductory information which is included in the Directory binder. If there are any corrections or deletions to be made to your listing, PLEASE complete the return-addressed, postage-paid card and get it back to CMS as soon as possible.

THERE WILL BE A COMPLETE UPDATING OF DIRECTORY LISTINGS IN MARCH, and this will be correct ONLY IF YOU COMPLETE THIS CARD AND RETURN IT AS SOON AS POSSIBLE.

There is now only one Physician's Directory; there will be only one channel by which your correct or corrected information can be printed in the Directory, and that is through the return card which you send to us.

ATTENTION CMS COMPONENT SOCIETIES

The new Directory contains a section devoted to Component Societies of CMS. We would like to publish current information concerning meeting dates, meeting places, key contacts, current officers and component committees. Send us the information.

ATTENTION SPECIALTY SOCIETIES!

There is a section of the new Directory devoted to your organization. At the moment, the section is empty. CMS wants to hear from you and your members. We can make this book into an actual resource for referral work and many other medically related matters, if you'll supply CMS with the information. We want this information for the April update, so please forward this information (any information pertinent to your Society) to our office.

ATTENTION HOSPITAL STAFF AND PERSONNEL

You'll notice in the book that we have included Colorado hospital names, locations and telephone numbers. We have made provision to carry much more of the hospital's vital statistics if you will supply them. Forward whatever information pertaining to your hospital you believe would be helpful to the medical community.

DEADLINE!

The deadline for this information is March 15, 1981; we need your help now to help you. GET ALL CORRECTIONS, CHANGES, ADDITIONS OR DELETIONS TO THE DIRECTORY TO CMS COMMUNICATIONS BY MARCH 15, 1981!

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March 14-15, 1981

Sheraton—Denver Tech Center

FRIDAY, MARCH 13

- 9:30 a.m. Medical Executives Group (MEG)
- 1:30 p.m. Board of Directors
- 7:00 p.m. Specialty Society President's Dinner
- 7:00 p.m. Board of Directors Dinner

SATURDAY, MARCH 14

- 7:00 a.m. Judicial Council Breakfast
- 8:30 a.m. Registration Opens
- 9:00 a.m. Credentials Committee
- 9:30 a.m. House of Delegates
- 11:30 a.m. Reference Committee Chairmen Luncheon
- 1:00 p.m. Reference Committee Meetings
- 5:00 p.m. Reference Committee Chairmen
- 6:00 p.m. Wine and Cheese Tasting Party

SUNDAY, MARCH 15

- 7:00 a.m. Component/District Caucuses
- 8:00 a.m. Registration Opens
- 8:30 a.m. Credentials Committee
- 9:00 a.m. House of Delegates

new officers

INTERMOUNTAIN MEDICAL SOCIETY

(Continued from page 22)

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Kent A. Petrie, M.D.
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INTERIM SESSION

MARCH 14-15, 1981

A stroll down the cobblestone paths allows for browsing through the fine shops located in the arcade off the lobby of the SHERATON DENVER TECH CENTER.

(Continued from page 22)

workers. As one example of the problem, a young man died of acute lymphatic leukemia. He had formerly worked at Rocky Flats. When I called the Rocky Flats plant they had no idea that this man had had this disease or had died of it although he had been dead for several years.

I refer readers to a letter published in the American Journal of Public Health last year which points out the reason for controversy and also provides some direction for change in policy in the area of radiation protection¹. I recommended to the National Radiation Policy Council last August that the radiation protection programs now divided between a number of federal agencies be given solely to those federal agencies whose primary mission is the protection of health. Those are the Department of Health and Human Services and the Department of Labor. They must have full authority and support for the basic research, the epidemiologic studies, the development of radiation protection standards and the means for investigation and enforcement.

This mission must not be given to those federal agencies which work hand-in-glove with the hundred billion dollar nuclear industry. There is a constant exchange of "experts" leaving regulatory agencies to enter employment in the industry which they regulate, and vice versa. University professors and health physicians retired from regulatory agencies may earn up to \$500 daily and expenses as consultants to the industry, if they have a performance record as a friend of the industry. There are serious questions which must be raised about the use of federal funds to solicit "friendly research" from universities.

I am reminded of the tobacco industry, which over the years has been able to hire scientists to question the relationship between cigarettes and cancer, heart disease and emphysema. Sufficient confusion, doubt and smoke have been generated by the industry so that even today we see our federal tax dollars given to subsidize the tobacco industry, a major public health problem.

Carl J. Johnson, M.D., M.P.H.
Director of Health
Jefferson County Health Department

¹Johnson, C.J.: Funding of radiation protection standards research. *A.J.P.H.* 69:181 Feb. 1979.

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LOCUM TENENS—COMPHEALTH. Our medical group can place a well-qualified physician in your practice during your absence. For more information call or write: Comprehensive Health Systems, Inc., 175 West Second South, Salt Lake City, UT 84101. Call: (801) 532-1200. 181-1-2B

PHYSICIAN'S ASSISTANT—experienced, mature, Board-Certified. Wishes to relocate to Colorado, preferably in medically underserved area. Write: Colorado Medicine, 1601 E. 19th Ave., Denver, CO 80218. 181-1-2B

INTERIM SESSION MARCH 14-15, 1981

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A Canadian researcher in the relatively new science of chronobiology found that Monday is the most dangerous day in the week for men to die of heart attack. Perhaps it's the stress of the return to work after a weekend.

Literally millions of families plagued by nighttime snoring of one of their members read with interest of a new approach—wear a cervical neck collar in bed, to prop up the chin and keep the airways open, thus curbing snoring.

The 1980 Nobel Prize in Medicine was won by two Americans and a Frenchman for research that led to discoveries about how the structure of cells relates to diseases and organ transplants. The three are Dr. Baruj Banacerraf of Harvard Medical School; Dr. George C. Shell of Jackson Laboratory at Bar Harbor, and Dr. Jean Dausset of the University of Paris.

APR 8 '81

colorado medicine

March, 1981

Volume 78, Number 3

STACKS

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When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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Lawrence E. Preshaw, MD, and Michael P. Hyman, MD, Denver
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COVER:

Our cover this month tells a story, though the story might not be clear to you in the Chinese symbols. The above professional card is the English translation of the Chinese, but what it says more than any written language can tell is, as Dr. W. Gerald Rainer of Denver said, "the language of medicine and human care transcends all racial barriers."

Read the interview, "China Hands," in this issue, page 67.

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*New person elected, however, he is
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resolved Dr. Hostetler will be listed.

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(Continued on next page)

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Colorado Heart Association Announcement

The Colorado Heart Association has relinquished coordination of the Advanced Cardiac Life Support Program to the Colorado Chapter of the American College of Emergency Physicians (ACEP).

Because of this transition, the roster of certified ACLS providers and instructors is incomplete. ACEP is compiling a complete list of these candidates and a computer program will be instituted to store this information and enable ACEP to notify those certified when their cards will expire.

If you have taken ACLS courses please respond in writing to:

American College of Emergency
Physicians/ACLS
700 Potomac Street
Aurora, Colorado 80011
Phone 341-1371, Ext. 516

Please provide a photocopy of current ACLS card and be sure to include the following information:

DATE OF COURSE
LOCATION OF COURSE
NAME OF COURSE DIRECTOR (M.D.)
LEVEL OF CERTIFICATION
SOCIAL SECURITY NUMBER
COURSE ROSTERS (ACLS INSTRUCTORS ONLY)

Thank you for your cooperation in this matter. Please notify ACEP with any change or additional information.

Health Reporting Radio-TV Workshop Tapes Available

(Update from AMA "Connections" newsletter)

Over eighty registrants from as far as Hawaii attended the two-day HEALTH REPORTING RADIO-TV WORKSHOP in Chicago, sponsored by the American Medical Association Office of Public Relations, October 2-4, 1980.

For those physician-members who expressed interest and were unable to attend, tapes of the sessions are available. For prices and mailing, contact Joyce Pollack, AMA, Office of Public Relations, 535 N. Dearborn Street, Chicago, Illinois 60610; (312) 751-6604.

Component Society Happenings

For the first time, the DENVER MEDICAL SOCIETY, The ARAPAHOE MEDICAL SOCIETY, and

their auxiliaries combined efforts in a "Meet Your Legislator Night" on February 9, 1981.

A reception was held at the DENVER MEDICAL SOCIETY Building to which both societies invited the Colorado Legislator representing their areas plus the leadership of the state legislature. Refreshments were served and the auxiliaries provided a variety of food for the large crowd of physicians, spouses and legislators. No formal program was presented. Brief welcoming remarks were made by the presidents of the two societies, J. PHILLIP NELSON, MD, for Denver and RICHARD H. THOMPSON, JR., MD, for Arapahoe, while most of the conversation about physicians' concerns for care of the medically indigent, the mental health programs and other legislative health subjects was on a one-on-one basis.

Another enjoyable evening was spent by physicians and spouses at the DENVER MEDICAL SOCIETY/AUXILIARY "Evening at the Art Museum" on February 19, 1981. Following a wine and cheese reception those attending enjoyed tours of the Thyssen-Bornemisza Collection of Old Masters. Considered one of the greatest private collections in the world of such masters as Rembrandt, Goya, Rubens and Van Eyck, the 57-piece display is on loan from Baron Hans Heinrich Thyssen-Bornemisza, whose art holdings are rated as second only to that inherited by Elizabeth II of England.

A very active member of the Denver Medical Society was sworn in recently by Mayor William McNichols, Jr. as Manager of Denver's Department of Health and Hospitals. He is JAMES L. KUROWSKI, MD, formerly Medical Director of Denver's Eastside Neighborhood Health Program. He replaces Abraham J. Kauvar, MD, who left last fall to assume a similar position heading the New York City department.

Hall of Life Expands - A Progress Report

Between June and December, 1980, a total of 20 weeks of classes for over 3,000 students were offered at the Hall of Life in a wide variety of health education topics. Program offerings expanded from a total of five for the first ten weeks to sixteen for the second ten weeks. This increase was due to recognized educational needs, and the desire to extend services to older age groups. The 1981 Spring and Summer Programs number 33, and are being targeted to the elderly, adult clubs and parent groups, as well as to pre-school and school age children.

(Continued)

Due to a grant from the HEGGEN LUNDQUIST PAINT COMPANY, valued at \$50,000, the Hall of Life is currently building three permanent classrooms and a workshop area. This construction will make it possible for the Hall of Life to serve up to 180 students per class hour, thus tripling its potential enrollment. Classrooms will continue to be outfitted with exhibits by the American

Medical Association, through September, 1981. These exhibits include: How Life Begins, the Anatomy of the Ear, Vision: Mirror of Health, The Brain, Nervous System, and How We Breathe. However, a conditional grant of \$75,000 from the Boettcher Foundation toward purchase of exhibits designed by the Richard Rush Studio in Chicago has stepped up fund raising activities. With only \$126,500 still to be raised, the Hall of Life is half way to realizing its dream.

Reprint. . . With Corrections

In February, COLORADO MEDICINE published some erroneous information pertaining to the Colorado Board of Medical Examiners. The information didn't go to many members, but any amount of wrong information is damaging. We listed the membership of the Board with two incorrect names. Current members of the Board of Medical Examiners are listed below - an asterisk indicates those members whose terms expire on May 3, 1981. Applications for positions on the Board must be in the Governor's office by April 1, 1981. You may contact the Government Affairs Division of CMS for additional information.

- * John Carroll, Boulder, public
- * Nelson Mohler, Denver, Osteopath
- * Ray Piper, Denver, Osteopath
- * Piero Albi, Denver, MD
- Christine Peterson, Denver
- Robert Lederer, Denver
- Bruce Wilson, Durango
- Henry Fieger, Denver
- James Philpott, Aspen
- Fredrick R. Paquette, Denver
- Michael Vitek, Delta

The Board is composed of 11 members who serve 6 year terms, meet quarterly and receive \$50 per diem.

The duties of the Board are to review applications and cases, to hold hearings and to aid the district attorney's offices of the state in prosecution of all persons, firms, associations, or corporations charged with the violation of any provisions of the Medical Practices Act.

AAMA Holds Malpractice Session in Denver

On Saturday, April 11, 1981, the Capitol Chapter CMSA will be hosting a seminar at the Radisson Denver Hotel, 1790 Grant Street, titled "Malpractice and the Medical

Assistant." BOB BRITTAIN, MD, CMS, will be the guest speaker for this one-half day session.

DR. BRITTAIN is President of Medical Liabilities Consultants Program and is a consultant to the Colorado Medical Society concerning malpractice insurance.

Registration deadline for this program is April 5, 1981, with a fee for members of \$15.00. Non-CMSA members fee is \$20.00. .3 CEU has been applied for. Those wishing to apply for CEU credit will be asked to pay \$2.00 for members, \$3.00 for non-members. You can mail application and registration to: Sunny McCarthy, CMA, 10700 E. Dartmouth, F201, Denver, CO 80014. Make checks payable to Capitol Chapter, AAMA.

Grievance of the Month

EDITOR'S NOTE: Beginning with the April, 1981, issue of COLORADO MEDICINE, you will see a monthly feature entitled "GRIEVANCE OF THE MONTH." This feature will be printed in the white pages of our magazine, and should be of interest to all our private practice physicians. In order to implement this feature, we are printing the March "GRIEVANCE OF THE MONTH" in the "At Press Time" section. Watch for it in the coming issues in "Departments" of the table of contents.

Complaint: Mary Brown writes the Grievance Committee complaining that Dr. Smith has refused to transfer her children's records to her new M.D.

Investigation: Mary Brown, recently divorced, has moved to a new community and needs her children's immunization records to keep them in their Day Care facility. Her former husband has not paid a bill owed Dr. Smith. Dr. Smith is refusing to release the records until the bill is paid.

Disposition: Dr. Smith is instructed by the Grievance Committee to send the records. According to AMA ethics it is unethical for a physician, who formerly treated a patient to refuse for any reason to make his records of that patient promptly available to another physician presently treating that patient.

ACP Studies GMENAC Report

In a preliminary report released in late-February, the American College of Physicians applauded the efforts of the Graduate Medical Education National Advisory Committee.

The GMENAC study, begun in 1976, projected a surplus of physicians in certain specialties by 1990 and recommended a series of actions to balance supply and requirements.

The ACP was especially pleased that "the federal government joined forces with representatives of the medical profession to develop comprehensive data for future manpower planning."

The ACP expressed reservations about certain areas of the experimental study, however, contending that many GMENAC projections are educated guesses and some of its methodologies new and untested.

OF PARTICULAR INTEREST TO MEMBERS OF CMS is a review of the GMENAC study done by CMS member William H. Call, MD, whose analysis of the GMENAC report will appear in the APRIL, 1981, issue of COLORADO MEDICINE.

From 'The Pink Sheet,' (the newsletter for Colorado Continuing Medical Educators).

Colorado physicians will soon be able to meet some of their continuing education needs through the use of "tele-Net," the long distance communication system developed by Elmer Koneman, MD, and CACMLE. Through Tele-Net, physicians will be able to participate directly in CME programs being held at designated Tele-Net locations throughout the state via a two-way telephone system featuring conference-style communication.

Medical Collection Service Inaugurated by CMS in 1980 Proves Effective

In mid-1980 your CMS Board of Directors approved a collection service offered by the I. C. System, Inc., a nationally recognized, effective, ethical, economical system for collecting delinquent accounts. It was (as of that approval) and is the only collection program recommended by your Association.

Under the name MEDICAL DIVISION/Credit Protective Service of I. C. System, Inc., the program initiates demand for payment in a courteous and diplomatic manner and continues to contact your debtor with increasing pressure, BUT ONLY to the extent permitted by law.

THE SYSTEM HAS PROVED HIGHLY EFFECTIVE in its first six-months of operation:

Through January 31, 1981, I. C. Systems, Inc., had collected \$96,829.13 on behalf of CMS members, reportedly more than any previous system during the same time period. Just one

more service provided by CMS.....TO CMS MEMBERS.

CMS Physician Appointed to the Colorado Board of Health

During late-February, 1981, Colorado Governor Richard D. Lamm announced his appointment of GATEWOOD C. MILLIGAN, MD (in the private practice of obstetrics-gynecology, Englewood, Colorado), to the Colorado Board of Health.

DR. MILLIGAN'S was the only new member appointed to the Board of Health. The following members were reappointed: RICHARD BLUESTEIN, ALBERT HADEN, and ROBERT SABIN. DR. MILLIGAN replaces BARRY RUMACK, MD, of Littleton.

VERLAND F. BEHRINGER, Hospital Administrator of Walsenburg, was appointed to the State Coordinating Council as a representative of HSA II.

Ray G. Witham Scholarship Announced by UCHSC

On January 30, 1981, Roy M. Schwarz, MD, Dean of the School of Medicine at the University of Colorado, announced that Jeffrey D. Kleiner of 777 Eudora Street, Denver, Colorado, had been awarded the newly-created RAY G. WITHAM SCHOLARSHIP.

The announcement was made by STEVEN L. DOBOVSKY, MD, Associate Dean for Student Affairs in the School of Medicine. DR. DOBOVSKY wrote Mr. Kleiner: "In recognition of your excellent research into membrane fluidizing agents and their effect on HMG COA reductase, I am pleased to award you, on behalf of Dean Schwarz and the School of Medicine, the RAY G. WITHAM SCHOLARSHIP. As a WITHAM SCHOLAR, all of your expenses in attending the Western Student Medical Research Forum in Carmel, California, on February 5 and 6, 1981, will be reimbursed.

I am very proud of you for your research accomplishments and hope that you will be able to continue your research interests throughout your medical career.

Congratulations on this fine achievement."

The RAY G. WITHAM SCHOLARSHIP was established for noteworthy and deserving students through a gift to the University of Colorado School of Medicine by DR. WITHAM, Immediate Past President of the Colorado Medical Society.

Universities Join Effort to Span the Globe in Medical Education

The University of Colorado Board of Regents announced in late-February that they had approved an agreement establishing institutional cooperation between CU's Health Sciences Center and the University of Riyadh, Saudi Arabia.

(Continued)

Under terms of this agreement the CU School of Medicine will provide the University of Riyadh College of Medicine assistance in developing quality medical education, research and patient care programs. CU School of Medicine faculty will share in education, health care and research opportunities in Riyadh.

Health Sciences Center Chancellor John W. Cowee said the cooperative venture between the two universities "underscores the commitment and dedication of our faculty to furthering medical research and education."

The pact, under negotiation for three years, includes:

- Agreement that the areas of cooperation shall be fulfilled in accordance with nondiscrimination standards promulgated by CU's Board of Regents;

- A mechanism for resolving potential disputes to mutual satisfaction through a coordinating committee and that if there can be no such resolution, either party may terminate the agreement on 90 days written notice, and;

- Provisions for a committee to monitor the operation of the agreement and to make efforts to enhance the spirit of cooperation between the two universities.

Colorado's Western Slope Focal Point of State Health Department Investigation of Dysentery Outbreak

On February 5, 1981, the Colorado Department of Health announced that it had conducted an investigation in the Montrose, Colorado, area concerning an outbreak of amebic dysentery, and the investigation showed that the outbreak had been linked to a type of enema treatment called colonic irrigation.

According to the Health Department's announcement, at least two dozen people who previously had colonic irrigations at a single office had developed evidence of amebic infection between May, 1979, and December, 1980. Nine of these patients underwent either total or partial removal of the colon, and six died.

"To our knowledge, this is the first time that colonic irrigation is known to be linked to the spread of the disease," said DR. GREG ISTRE who headed the investigation along with DR. KATHLEEN KREISS. Both are State Health Department Epidemiologists.

DR. ROBERT SIMMONS, a gastroenterologist, and DR. M. G. KLEIN, a pathologist, both of St. Mary's Hospital of Grand Junction, originally alerted Mesa County and state health officials to the unusual number of cases of amebic dysentery. DR. THOMAS CANFIELD, pathologist at Montrose Memorial Hospital, was also notified and he and other area physicians examined hospital medical records as well. They found a total of 14

patients who had had colonic irrigations at a Montrose Chiropractic office and who subsequently developed bloody diarrhea, a key symptom of amebic dysentery.

DR. ISTRE said his team of eight investigators then tried to contact about 220 patients who had been seen in the chiropractic office between September 1 and December 31, 1980. DR. KREISS said about 180 persons were reached, some of whom were from out of state.

DR. RICHARD HOPKINS, Director of the Colorado Department of Health Communicable Disease Control Section, said the use of colonic irrigation has apparently increased over the past several years and that there are presently no regulations governing its use.

ON FEBRUARY 27, 1981, the Colorado Department of Health asked the Board of Chiropractic Examiners to issue an "advisory memorandum" to all licensed chiropractors, urging them to take special precautions with the enema treatment, after having identified at least ten of the patients who underwent this treatment, seven of whom died. The Health Department memorandum included a "request that chiropractors consider diarrhea, especially bloody diarrhea, as a warning sign against the colonic irrigation treatment and that it include recommendations for the cleaning and sterilizing of the machine used for the treatment." The health Department also took the following actions:

- Sending a summary of findings of its investigation to all physicians licensed in Colorado and, with the cooperation of the Chiropractic Board, to all licensed chiropractors.

- Working with the U. S. Food and Drug Administration, which is responsible for machines used in medical treatment, in the examination of how the machines are constructed to determine whether they can be sanitized and safely used.

- Offering to provide a free clinic for testing for amebic infections to the more than 600 people in the Montrose area who were patients of the chiropractic clinic and had undergone the colonic irrigation treatment since 1977.

- Conducting inspections of the sanitation of other colonic irrigation machines.

The Health Department said that chiropractors have voluntarily stopped doing the colonic therapy while its safety is being investigated.

THERE WERE NO PHYSICIANS IN THE AREA CONDUCTING ANY SUCH TREATMENT OR THERAPY. IF SUCH STATEMENTS HAVE BEEN MADE BY ANYONE, THE STATEMENT AND ITS SOURCE SHOULD BE REPORTED TO THE COLORADO MEDICAL SOCIETY AND TO THE MEDIUM WHICH PUBLISHES SUCH INFORMATION.

to the letters the editor

Editor,
Colorado Medicine
1601 East 19th Avenue
Denver, Colorado 80218

Dear Editor:

I want to comment briefly on the article by Drs. Balkany and associates regarding the current state of the art of the cochlear prosthesis. The prosthesis being used by Dr. Balkany was developed by Dr. William F. House. The prosthesis is currently being given clinical trial as an experimental device under the guidance and control of the Food and Drug Administration. Dr. Balkany, among others, has been designated a co-investigator in this project. The device has not yet been approved for general use, however, and to call it "a device which is now in clinical use" is to blur its true status.

Although the single channel cochlear implant described in this paper does not permit the recipient to understand speech, there are multichannel cochlear implant devices at a similar stage of development which *do* permit modest discrimination in the absence of visual cues. One of these, developed by Drs. Michelson and Schindler¹ at the University of California in San Francisco, is commencing similar clinical trials. It uses a multiple electrode array passed through the round window. A similar multichannel device is under development by Dr. Blair Simmons and associates at Stanford University.² Multichannel implants are also being installed on an experimental basis in France, Spain, Australia and Germany. The multichannel devices, particularly the one developed by Dr. Michelson and Schindler, promise major improvements over the performance of the House single channel device.

William H. Call, M.D.

REFERENCES

- ¹Michelson, R.P. and Schindler, R.A.: "Multichannel Cochlear Implant. Preliminary Results in Man." *Laryngoscope* 91:38-42, 1981.
²White, R.L.: "The Stanford Artificial Ear Project." *The Stanford Engineer*, Spring/Summer, 1980, pp. 3-10.



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CFMC To Utilize Severity of Illness/Intensity of Service (ISD) Criteria Approach for Concurrent Review Capability

On January 1, 1979, the Colorado Foundation for Medical Care (CFMC) implemented an acute care hospital review system which involves retrospective data collection and profile analysis. One of the components of this "retrospected review" system is "focused review" i.e. reimplementation of concurrent review when a hospital, physician(s), diagnoses or procedures are identified which indicate a need for intensified review.

The CFMC has also performed review for private insurance carriers and industry in the past and continues to receive requests for concurrent review from private employers and insurance carriers.

Recognizing that a concurrent review system is an integral part of the CFMC acute care hospital review program, the CFMC has made every effort to develop the most efficient and effective system available to meet current needs. At its January 21, 1981 meeting, the CFMC Board of Directors, after reviewing the Severity of Illness/Intensity of Service (ISD) criteria approach, approved the use of this approach for concurrent review in the acute care hospital review program. The Severity of Illness/Intensity of Service approach was developed approximately two (2) years ago by InterQual under government grant and is currently being used by over 100 PSRO's across the country.

Essentially, in this approach, criteria have been developed by physicians which seek objective, clearly definable, documented, readily accessible data points which address three fundamental review issues:

1. Is the patient sick enough to warrant acute hospital care? The SI (Severity of Illness) criteria identify this.

2. Are the services required complex enough to warrant acute care hospitalization? The IS (Intensity of Service) criteria identify this.

3. Has the patient reached a point in his/her care that would indicate that discharge should occur? The DS (Discharge Screen) criteria assess this.

The criteria have been developed to be used as a screening tool. As such, they are applied by a Review Coordinator. Where the case does not meet either SI/IS criteria, or in the case of Discharge

Screens, does meet the criteria, the Physician Advisor is called in to review the case. The Physician Advisor, as was previously true in the CFMC concurrent review hospital program, is the only individual who can make a decision to deny a patient's hospital admission or continued hospitalization.

The ISD criteria include two types: generic and body system specific. The generic criteria are applicable to a large number of patients regardless of diagnoses, problems or conditions which may be the reason for hospitalization. Backing up the generic system are specific criteria for twelve body systems as well as psychiatry. The system also provides for elective surgery and major procedure review, but for this purpose, justification for surgery criteria that reflect the "indications" for the surgical procedure must be developed such as those developed by the CFMC Health Care Standards Committee (HCSC) in 1978. However, pre-operative length of stay and overall length of stay could be reviewed at this time with existing resources.

PSRO's who have experience using the Severity Illness/Intensity of Service approach have recognized the following advantages over the diagnosis-specific criteria approach:

- a. Review Coordinators can review 2-3 times as many cases;

- b. Physician Advisor referrals are increased initially, but the Physician Advisors feel the cases are more pertinent to physician review;

- c. A greater percentage of Review Coordinator referrals to the Physician Advisor are cases with questionable justification for hospitalization;

- d. Review is focused on medical necessity of the hospitalization rather than validation of diagnosis and appropriate length of stay norms.

Some points which may be considered limitations to the approach developed by InterQual are the following:

- a. If, in addition to items such as preop stay and total length of stay, greater emphasis is to be placed on review of elective surgery, indications for surgical procedures must be developed locally;

- b. The criteria require local modification (The Foundation's Health Care Standards Committee has accomplished this).

- c. Quality of care provided must be addressed by a separate methodology as the criteria review "quality" only in a gross sense.

In the judgment of the physicians on the Health Care Standards Committee, who analyzed the criteria and approach in detail in the course of criteria modification for Colorado use, the Severity of Illness/Intensity of Service approach is much more consistent with the clinical process than the diagnosis-specific approach (the "Rainbow Book") previously utilized by the Foundation for concurrent review.

—Rachelle Kaye

standards of practice

How are bills and statutes constructed? A valid question during this long session of the Colorado General Assembly, particularly in consideration of the number of health-related bills now before the legislature.

While serving in the United States Congress, Al Ullman gained some notoriety for the following explanation of a bill:

"Look! Just because you don't understand it . . . and I can't explain it . . . doesn't mean it's not a good program."

Unfortunately, Ullman's remark is a good summary of the state of the art in bill drafting in Colorado. As a result, physicians who are interested in public policy have discovered the need to be able to decipher bills themselves. This column explores some basics of such "statutory construction."

STATUTES PRESUMED PROSPECTIVE

Unless contrary legislative intent is clearly manifest, a statute is presumed to affect events occurring on or after the date legislation is enacted.

IRRECONCILABLE STATUTES

If statutes enacted at the same or different sessions of the general assembly are irreconcilable, the statute which is latest in its effective date prevails. When irreconcilable statutes have the same effective date, the statute which is latest in passage prevails.

AIDS IN CONSTRUCTION

The Colorado legislature has specified some matters which may be considered in interpreting its laws. Those include:

a) The legislative history, including records or testimony about the object sought to be attained and circumstances under which a statute was enacted.

b) The common law, former statutory provisions, and laws upon similar subjects.

c) The administrative branch's construction of the statute.

d) The legislative declaration or statement of purpose.

In addition to those specified aids, there are some common law tools for construction which are widely accepted, although not legal dogma.

Expression unius est exclusio alterius means: the expression of one thing impliedly excludes another thing. For instance, a bill says that rifles, pistols and bows and arrows are dangerous weapons which

(Continued on page 79)

Authorities Arrest Quaalude Fraud Suspect

NOTE: The following is excerpted from a letter to the editors of *Colorado Medicine* from John L. Vermilye, Director, Department of Public Safety, Lakewood, Colorado. The letter concerns a physician's bulletin which was published in the January issue of *Colorado Medicine*, regarding a "Quaalude Fraud" being perpetrated on front-range doctor's offices over several months of 1980.

"I wish to thank you for publishing the announcement concerning the cardiac patient—Quaalude fraud, which led to the arrest of (a suspect).

The arrest occurred when (a Northglenn physician) had read the flier you published and recognized the suspect as a patient then in his office. The Northglenn Police arrested (the suspect) who then confessed.

Charges including criminal impersonation and obtaining drugs by fraud have been filed against the suspect in Jefferson County. Seven additional doctors from as far away as Colorado Springs have called to report they have been victimized and their complaints will be forwarded to their local law enforcement agency. We ask any physician who has been defrauded to call Sergeant John Miller, 234-8542, Lakewood Police, and he will relay the complaint to the appropriate agency.

Again, thank you for your cooperation in this matter."

Additional information which the authorities have shared with Colorado Medical Society indicates that the subject allegedly practiced obtaining drugs by fraud and then transported the drugs to another state for sale. The editors of Colorado Medicine are extremely pleased that such a positive response was to be gained from physician readership, and encourage such future use of the physician's magazine.

Foundation Expands Health Insurance Coverage to All CMS Members

The Colorado Foundation Trust Board of Directors has announced that it has voted, effective February 1, 1981, to extend its newly expanded Group Health Plan to all members of the Colorado Medical Society.

This health care plan may be unique among all
(Continued on page 81)

Computers In Medical Practice

There are two reasons why computers are likely to play a large part in the lives of physicians within the next ten to fifteen years. First, the reasoning processes that doctors go through in diagnosing patient ills and designing treatment programs are exactly the kinds of things that computers do best—only computers never forget any relevant piece of information. Second, by using computers, physicians can keep the records of their practices far more efficiently than they can by any hand system. And efficiency means cost savings. So in the long run, computers will enable doctors to do a better job of practicing medicine and of managing their office and hospital practices more efficiently—better patient care and better economics.

Here is a summary of the way computers will be used in medicine in the future:

OFFICE PRACTICE

Computerized billing systems for doctors' offices are readily available for those who want them. But in the long run, information systems for doctors' offices must be built around the doctor/patient encounter. All other records—medical files, drug and x-ray information, appointments and billing—are related to the doctor/patient encounter. Future computerized office data systems should be concerned with the whole office and not with just a part of the office operation. Currently, systems do exist that are powerful enough to support comprehensive office practice data systems, but they are extremely expensive, more appropriate for the very large complex practice such as an HMO, than for a three-physician office practice. Computer specialists are working feverishly to develop computers and software packages that are cheap enough to be afforded by even the smallest practices. Within two or three years, a doctor who wants a comprehensive data system for his office should be able to install one for under \$20,000.

HOSPITAL DATA SYSTEMS

Most hospitals have computerized billing systems and many are using computerized retrospective patient data systems. Retrospective systems put patient data into the computer at the time of discharge. By 1990, we will see wide-spread installation in hospitals of "real time" or concurrent patient data systems which will store and process patient data as it is generated—test results, treatment orders, medication, summaries of progress notes—all organized and immediately retrievable by those caring for the patient. Such systems now exist in two or three of Colorado's largest hospitals. As we gain experience with such systems and the cost of computers drops,

more and more institutions will be able to take advantage of this way of improving the efficiency and effectiveness of patient care.

CLINICAL INFORMATION SYSTEMS

Currently there are available to physicians throughout Colorado clinical information systems which, in a few minutes, can provide detailed information concerning problems of patient care. The National Library of Medicine operates one such computerized information system which can be accessed by terminals located anywhere in the United States. Both the University of Colorado School of Medicine and the Denver Medical Society Library accept requests for searches of this clinical information system. The telephone number for Denison Library, UCHSC, is 394-7469, and the WATS number for the Denver Medical Society Library is 1-800-332-4150 (outside the Denver metropolitan area).

This service usually includes a discussion with a reference librarian who is expert in converting a doctor's clinical problem into language that relates to the computer. Print-outs from a computer search consist first of a bibliography of articles. Articles that are clearly useful and relevant can be photocopied and put in the mail immediately.

Eventually even more sophisticated clinical information systems will be available to doctors with the information stored in desk-top computers so that up-to-date information concerning clinical problems will be available in the computer on a subscription basis at the moment the physician needs it.

BLUE SKY POSSIBILITIES

Eventually, all medical knowledge will be computerized and organized in a branching system so that a beginning medical student can use it to find out about the basics of, say, hepatitis while at the same time an advanced researcher can branch down through the system to the most advanced and esoteric knowledge about the subject.

The next step in technological development, which is already under experimentation, is to combine the printed information from the computer with visual information. This will be done by combining the computer with a videodisc, each of which is capable of storing thousands of visual images, any one of which can be displayed in less than a second. Thus, a physician who is using a computer information system to obtain information about a skin lesion, will have before him not only a summary of the methods of diagnosis and treatment of the lesion, but also color video pictures of the lesion. The computer, of course, will also be programmed to print out information and instructions for the patient concerning the illness.

A one-hour presentation with color illustrations on the subject of Computers and Telecommunications for Physicians is available by calling Kevin P.

(Continued on page 82)

Colorado Physicians and THC

A preliminary report by the University of Colorado Health Sciences Center. This report concerns a Denver-based national study of the effectiveness of THC treatment.

Approximately 6,500 cases of cancer are diagnosed each year in Colorado. About 3,000 of these patients undergo some type of chemotherapy which creates ill side effects of which nausea and vomiting are the most common.

A cancer patient's ability to tolerate chemotherapy would be greatly increased if this uncontrollable nausea and vomiting, which can be violent and long-lasting, could be controlled or eliminated. This might be possible by using delta-9-tetrahydrocannabinol (THC), the active ingredient in marijuana.

The University of Colorado Health Sciences Center and the AMC Cancer Research Center and Hospital, Denver, are involved in a national study to determine the effectiveness of THC in controlling such nausea and vomiting.

"THC will be given to two groups of cancer patients: those who are new and will be getting drugs known to usually cause nausea and vomiting, and those who have had such problems in the past," explained William Robinson, M.D., Ph.D., professor of medicine, CU School of Medicine, and a medical oncologist.

There's no limit on the number of patients who will be accepted for the study. However, "cancer patients cannot just walk in the door and request THC," stressed Linda Krebs, a nurse oncologist at the Health Sciences Center.

"There are stringent requirements," added Dr. Robinson. "Patients have to be between the ages of 14 and 90 and referred by a physician. There also has to be verification both of the diagnosis of cancer and that the drugs they will receive or now are getting produce nausea and vomiting."

The use of THC, however, may be associated with possible adverse reactions in several groups of patients.

These categories include children and adolescents, because of possible THC-induced abnormalities in neuro-hormonal regulatory systems; epileptics and other patients with seizure disorders because THC can enhance seizure activity; pregnant women because of possible embryotoxic effects; schizophrenics and other patients with mental instabilities since the drug can promote and enhance dysphorias; elderly patients; patients with cardiovascular problems since THC may induce rhythm abnormalities, and patients with impaired hepatobiliary function since THC is excreted in the bile.

It doesn't matter, though, the type, site or stage of

cancer, or any prior therapy. "Patients who are receiving radiation therapy where nausea or vomiting may be encountered also are eligible," Krebs said.

There have been a number of side effects reported with delta-9-THC. They may be expected to begin from 60 to 90 minutes following the first dose of THC, and usually resolve within 24 hours after the last dose. The most frequent side effect reported is sedation. Others include disorientation, dizziness, hallucinations, poor concentration, dysphoria, headache, sleep disturbances, and cardiovascular, autonomic, neuromuscular and endocrine-reproductive changes.

THC is available in several doses. The initial daily dose for most patients weighing between 45 and 90 kilograms, noted Krebs, is 40 milligrams each day; for patients weighing more than 90 kg, 60 mg each day. The doses may vary, depending upon the individual patient.

THC can be given either on an inpatient or outpatient basis, currently just at University Hospital, Denver. However, Krebs noted that outpatients ordinarily will not be given more than 2½ days supply at one time.

Colorado joined some 24 other states which have legalized marijuana's medical use with passage in 1979 of House Bill 1042, introduced by Rep. Miller Hudson, D-Denver. The state subsequently allocated \$15,000 to undertake the study of THC.

Currently, University Hospital is the only facility in Colorado which is participating in the National Cancer Institute (NCI) study and dispensing THC. Dr. Robinson and Rep. Hudson, however, recently re-wrote the original House bill so that "any hospital-based pharmacy or physician in Colorado who fulfills NCI's guidelines can dispense and prescribe THC," Dr. Robinson noted.

He added that the re-written bill, which is expected to be among the first items introduced during this legislative session, is expected to pass. Passage of the new bill would mean that more physicians could prescribe THC for their cancer patients, and more hospital-based pharmacies could dispense it.

A physician is eligible to prescribe delta-9-THC, according to the NCI guidelines, if, among others, he has experience in cancer therapy, has a current Drug Enforcement Administration registration and number, is officially registered with a participating pharmacy and the NCI, affirms that the patient has signed an informed consent form, agrees to limit drug usage to the indications outlined in the guidelines, and will report any adverse drug reactions immediately to NCI.

Physicians who are treating cancer patients can contact Dr. Robinson at 394-8801 for more information.

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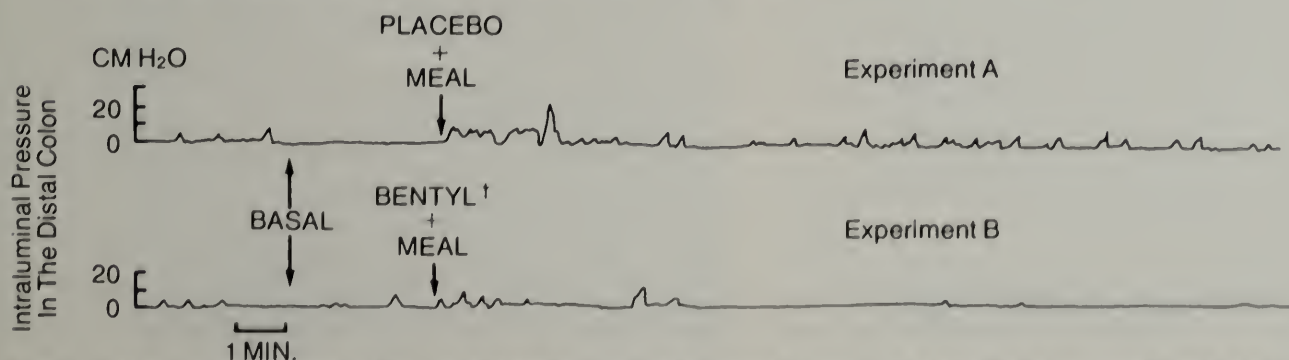


Fig. 1. In ten irritable colon patients, the mean motility index for the colonic wave patterns following a meal and intramuscular placebo was calculated at 86 ± 28 . On a separate day, the mean motility index for the colonic wave patterns following a meal plus intramuscular Bentyl[†] was calculated at 14 ± 8 . The decrease in motor activity induced by Bentyl[†] was statistically significant ($p < 0.05$) in spite of the wide range of the standard error of the mean. The above graph illustrates the intraluminal pressure findings in one of the patients typical of the group studied.

*This drug has been classified "probably" effective for this indication

from a study by A.R. Chowdhury
and S.H. Lorber, 1980

[†]Although the dose of Bentyl used to show pharmacologic effect was 50 mg., which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg. dose. Presumably, the same pharmacologic effect, as shown in Figure 1, would follow. These observations do not constitute evidence of efficacy.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have evidenced respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:

Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.

Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage

Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.

Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.

NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

Injectable dosage forms manufactured by
CONNAUGHT LABORATORIES, INC.
Swiftwater, Pennsylvania 18370 or
TAYLOR PHARMACAL COMPANY
Decatur, Illinois 62525 for
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Merrell

1-6707 (Y175C) MNQ-443R

DIAL FOR DRUG INFORMATION

Colorado: (800) 332-6475 Toll Free
Denver Metro area: (303) 893-DRUG

The Rocky Mountain Drug Consultation Center (RMDCC) is now available statewide to health professionals. You may now dial (800) 332-6475 toll-free from anywhere in Colorado to obtain rapid, unbiased and clinically relevant responses to drug information questions or patient-specific drug therapy problems. Call the Center from 8:00 AM - 5:30 PM Monday-Friday for any drug related question, including:

- Adverse Drug Reactions
- Drug Therapy of Choice
- Investigational Drug Information
- Drug Therapy in Pregnancy or Breast Feeding Period
- Comparative Drug Efficacy
- Drug Dosing in Disease States (Renal/Hepatic Disease)
- Drug-Drug Interactions
- Drug-Lab Test Modifications
- Foreign and U.S. Drug Identification
- Drug-Food Interactions

The RMDCC is staffed by clinical pharmacists trained to selectively retrieve, evaluate and communicate clinically-relevant information to solve a specific drug therapy problem. The RMDCC staff has immediate access to original (primary) literature from over 1,000 medical and pharmaceutical journals; over 250 textbooks in specialty areas; foreign compendia; and access to MEDLINE/TOXLINE computer terminals. In addition, the Center utilizes a computer-output drug information system (DRUGDEX®) to provide quick, accurate responses to drug information requests.

The RMDCC has been endorsed by the Colorado Medical Society, the Denver Medical Society, and the Colorado Pharmacal Association.

For further information regarding the RMDCC, call or write Christopher S. Conner, Pharm.D., Director, Rocky Mountain Drug Consultation Center, 645 Bannock Street, Denver, Colorado 80204.

Hypothermia

Hypothermia is a health problem you may hear more about during these cold months. According to the American Medical Association, most people don't face a health hazard from living in cooler surroundings. But for some—the elderly and those who cannot afford adequate heating—the risk is greater. Slurred speech, an irregular heartbeat or dizziness may be signs of hypothermia and must be treated immediately.

China Hands

EDITOR'S NOTE: *Tales told by the "old China Hands" (those anglo-saxons who were on station for the American or British government, the merchant seamen and the missionaries) have faded into the history books. A new China is emerging, and the "China Hands" of modern-day are the skilled and devoted Chinese medical doctor, the surgeon and the physician specialists. Helping these are the 'paramedicals' and the 'middle-ranked' doctors, the Chinese answer to their enormous need to satisfy basic health care immediately. But they realize the need for qualified doctors and they will be in a continuing state of flux . . . of change. In the shortest amount of time they have moved to provide the greatest amount of medical care.*

During 1978, W. Gerald Rainer, MD, of Denver toured mainland China, visiting many of the medical and clinical settings of provincial and urban life. He was able to observe, as a member of their teams, cardiovascular and thoracic surgeons in their practice. His host in Shanghai was Dr. Pan-Chih, Head of the Department of Thoracic and Cardiovascular Surgery in the Shanghai Chest Hospital. Dr. Pan was invited to visit the United States and Denver as guest of Dr. and Mrs. Rainer. In January, Dr. Pan traveled with Dr. Bernard Huang of Tufts University to Denver, where they stayed for three days, during which time Colorado Medicine was given the following interview.

NOTE: *In the interview, CM indicates the interviewer from Colorado Medicine, and PAN refers to Dr. Pan-Chih.*

CM: Dr. Pan, what is the status of medical care in China today?

PAN: After liberation, the medical care has improved very much. For instance, the infectious disease, such as small pox, typhoid, and polio have been eradicated. And venereal disease, there is none. No more! Some schistosomiasis, but under control. Tuberculosis has also declined. So the problem now is a heart and cardiovascular problem, and cancer. After the liberation,* I think, great medical progress has been achieved. For example, during my internship . . . 1948 to 1949 . . . in the medical ward there were large numbers of typhoid fever and some other kinds of infectious disease patients. Now, in China, the acute infectious disease is basically eradicated. In Shanghai, I think, the incidence of pulmonary tuberculosis is about six in one-hundred thousand. It is very low. And schistosomiasis is controlled . . . by treatment of patients and treatment of



Ben Eiseman, MD, Prof. of Surgery, Univ. of Colorado School of Medicine, with (r) Pan-Chih, Head, Dept. of Thoracic and Cardiovascular Surgery, Shanghai Chest Hospital, China.

the water . . . through hygiene. The intermediary host is a snail, and to eradicate the snail is very difficult.

CM: What has been most helpful in your health care?

PAN: I think . . . vaccination. BCG is quite widespread. Polio, basically, has been eradicated by oral administration.

CM: How is medicine practiced in China? I mean, is there any longer the private practitioner, or is all medical care socialized?

PAN: I think about one-hundred thousand have free medical care . . . completely free. Drugs, medical care, hospitalization, everything is free. The government pays for all. And for the peasants, I think about 80 percent of our population, they have cooperative medical care. They pay some two or three or four yen per year, and that pays for all medical care. So . . . big, big progress has been made.

CM: Don't you have a new hospital in Shanghai?

PAN: Yes . . . for heart disease . . . and now much improved nutritional help. But there is also some stress in the city. We have some coronary disease, but we think that incidences of this are lower in China as compared to western countries.

CM: Going back to the government paying for medical treatment, Dr. Pan, we talked about the cost effectiveness, when people pay only three or four yen per year, and your new hospital in Shanghai is a government hospital; then you and other physicians are working for the government medical program, is that correct?

PAN: Yes.

CM: Is cost an important item in China in respect to health?

* "Liberation" refers to the rise to power of Chairman Mao Tse Tung in the late 1940s and early 1950s.

PAN: I think the cost is very cheap . . . very low. For example, registration fee for the first time . . . twenty cents. And later on . . . ten cents. For hospitalization, about one yen per day. That means sixty or seventy cents in U.S. dollars per day for hospitalization. And the operation fee, of course, is paid to the government. The most major operation . . . is 35 yen. That means twenty U.S. dollars, and it cannot exceed that limit. An open-heart or replantation, any kind of operation, the upper limit is 35 yen. And the drugs are also very cheap. You see, in China everything is cheap. For food, for the average person in the city of Shanghai, which is already very expensive, ten to fifteen yen is enough. That means seven to ten U.S. dollars a month. For housing, apartments, about two to five yen a month; this is one to three U.S. dollars a month. For clothing, a suit is less than twenty yen . . . can wear for several years.

CM: How many of the one billion Chinese live along the coast of the China Sea or the Yellow Sea?



Bernard Huang, MD, Tufts University School of Medicine; W. Gerald Rainer, MD, Thoracic Surgeon, Denver, President of the Rocky Mountain Vascular Surgery Society; Pan-Chih, MD, Thoracic and Cardiovascular Surgeon, Shanghai; and Henry Swan, MD, Clinical Professor, Department of Surgery, University of Colorado School of Medicine. Drs. Huang and Pan were the Denver guests of Dr. and Mrs. Rainer.

PAN: Most of China's population . . . the majority are along the coast.

CM: Doesn't that mean that your health care system is being impacted by the majority of the population? For instance, your new hospital in Shanghai is treating most of the heart and cardiovascular illness in China?

PAN: For our hospital, all patients come from every part of country . . . whole China! Of course, every province has a center . . . a provincial medical cen-

ter. The patients who wants to come from Shanghai, free of charge, must have a certificate from the provincial medical center to certify that his disease cannot be cured in that province. Then he can transfer to Shanghai, free of charge. If he pays himself, he can come over any time without certificate.

CM: But you said your hospital had a waiting list of patients for . . . how many months?

PAN: Yes . . . three-thousand for open heart . . ."

CM: How long must they wait?

PAN: Some simpler cases come quicker . . . usually several months or one year. Some complicated form sometimes takes three or five years. This is the reason why the government decided to establish a new hospital for us.

CM: How many physicians do you have in your hospital?

PAN: In our hospital, Shanghai Chest, (we will get in before May first) a total of 400 beds, two-thirds are surgical beds, and eight operating rooms. We have a total medical staff of about six-hundred and seventy . . . and about one-hundred and ten physicians, more than one-hundred and fifty nurses and nearly one-hundred technical personnel. In all of the hospital they have five departments: Surgical, Anesthesiology, Radiology, Cardiology and Pulmonary Disease. And we perform about fifteen-hundred thoracic cardiac operations a year, in which two-thirds are cardiac operations, one-third general thoracic operations. About four-hundred open-heart operations. And our hospital is one of the biggest treatment centers of thoracic-cardiac disease in China. In my department of thoracic-cardiovascular diseases, we have 47 graduated doctors, including anesthesiologists.

CM: Dr. Pan, do you have foreign physicians practicing in China?

PAN: Yes. Several years ago we have an Indonesian doctor who was graduated in Germany, then came to my department and worked for eight years. After Cultural Revolution he went back. And now he works in Holland. We do have Third-World people. In Africa . . . Africa sends doctors to be trained in China, and then send them back to Africa. College students study medicine, study Chinese culture and language . . . we have many. But as practicing doctors, we have very few.

CM: What is happening in China regarding medical schooling and training?

PAN: In China now, six years primary school. Of course the Chinese language is very difficult, so we spend more time on that. Six years in middle school . . . in your country you call this highschool. Then, four years in college for some industrial, such as chemistry. For medical school, though, six years: five years study and one year internship . . . that hap-

pen only after smashing the Gang of Four.

CM: How many persons are studying medicine in China now, and how many physicians would you be turning out each year?

PAN: I don't know the exact number. In 1949, I think in the whole of China there were twenty-thousand. Now, of course, many, many times that. I don't know exact number. Also, you have a large percentage of women in medical school . . . maybe more than 40 percent, especially in gynecology, ophthalmology and pediatrics.

CM: Since it is a totally government operated medical service system, do the new graduates have any choice as to where they will practice?

PAN: After graduation they can fill out a form to express their preference. Of course, their wishes sometimes can be satisfied but the distribution is mainly by necessity.

CM: You have referred to what you call 'paramedics'. What is a paramedic in China?

PAN: We have the middle-ranked doctors, so-called. Actually, they are paramedics, such as anesthetists. Shortly after the liberation the government issued some regulations for qualifying the doctors. Now, after Cultural Revolution, things need to be redone. Some rectification is needed, but it is not yet complete.

CM: Do you have private practice of medicine in China?

PAN: Before liberation, there were a few 'traditional' doctors who were licensed to private practice, but now all graduates of medical schools work for the government. The paramedics work in factories, in communes, and for something very severe they cannot deal with the patient is transferred to the county hospital (commune hospital), then to city hospital. In the city the hospitals are ranked in three levels: the common city hospital, the center-city hospital, and the specified hospital, like Shanghai Chest Hospital.

CM: You mentioned that medical education is now being done through public television. Can you describe this?

PAN: Yes . . . in recent two years in Shanghai there is established a television university. There is medical school, school for industry, and many others. The University has a headquarters building and is organized very well. Medical students are all medical personnel who are now working in hospital as middle-ranked medical personnel. They get into the television school by examination, and accept education in afternoon and nighttime. The professors, associate-professors, lecturers and assistant professors are all from Shanghai First Medical College and Second Medical College. They are invited to teach the students on television, and are organized into

teams. Each hospital has fifteen or twenty students organized as a team, and the teacher then brings them to medical school to practice with microscope, see slides, witness dissections, and so on, for three years. Then, they have one year in externship, distributed to different hospitals and maybe attend out-patients, follow the patient runs . . . even scrub. Of course, after they have graduation and certification they are not qualified physicians, but are high-quality paramedics. After several years, if they work good, through certain examination it is possible to promote them as doctors. I think it is quite a good program. Only a few percentage of the students can get into the University. It is very new . . . but it is a trial, an experiment. In China, it takes about eight years after graduation. For example: at least two years or so for general surgery, four years resident in rotation in general surgery and chief resident, and then at least two years in general thoracic surgery, then some two to four years in cardio surgery, then he can be qualified as staff surgeon; he can perform some open-heart independently. It takes at least eight to ten years. In China we have a post-graduate training course. We train, every year, fifteen to sixteen thoracic surgeons who come, by examination, from all over China and have at least five years after graduating training. After acceptance, we distribute them to four hospitals in Shanghai. There were 200 hours of teaching, then they go to the bedside for training. After one year in training they can go back to their own hospital and they can do some simple thoracic operations. After several years they can come back for a refresher course.

EDITOR'S NOTE: *While in Denver, Dr. Pan was able to observe thoracic surgery and observe office and clinical treatment of patients. With those people Dr. Pan visited, he left a continuing sense that, in medicine and human care, there is no language or racial barrier.*

Professional Education Update The Diagnosis of Prostatic Cancer

Videocassettes and 80-piece color slide set with script. Film.

Two patients with cancer of the prostate—one early and one more advanced—are followed to demonstrate the battery of diagnostic procedures now available to the clinician. The importance of routine digital prostatic examination is stressed, and the technique reviewed. The film also includes: tips in the differential diagnosis, advantages and disadvantages of open and closed biopsy, and the current methods of staging.

Patient education literature available for doctor's offices. For more information write or call: The American Cancer Society, 1809 E. 18th Avenue, Denver, Colorado 80218, (303) 321-2464.

Thin Needle Aspiration Biopsy In A Service Hospital

Preshaw, Lawrence E. and Hyman, Michael P., Denver, Colorado*

Abstract

Thin needle aspiration biopsy as a new procedure in a community hospital is examined for accuracy and usefulness. Trial runs in the form of aspirations of surgical specimens with histologic confirmation of diagnosis provide expertise and confidence in the handling of clinical specimens. The procedure can be used to provide accurate diagnosis in community hospitals if physicians familiarize themselves with it properly. Savings in morbidity and expense justify the technique.

Introduction

Thin (skinny) needle aspiration biopsy is a multipurpose procedure for obtaining tissue diagnosis with a minimum of expense and morbidity. Its use in Europe is routine and widespread but acceptance in the United States is variable. This article reviews the technique and its uses and describes the incorporation of thin needle aspiration into the diagnostic armamentarium of a pathology department in a service hospital.

Materials and Methods

The pathology department at Presbyterian Medical Center, Denver, Colorado, after reviewing the technique and its uses determined to gain experience with it. Surgical specimens were sampled with the thin (22 gauge) needle. These were read without knowledge of the clinical impression or histologic diagnosis, but the site of aspiration was known. Forty-six specimens were collected, diagnosed by thin needle aspiration and then compared with the histologic preparation. Needle aspirates were prepared in the cytology section and tissue blocks were completed in the department of histology.

Soon thereafter clinical specimens were accepted. Some were done in an emergency room on an outpatient basis by clinicians and some were

performed in the radiology department of Presbyterian Medical Center under fluoroscopy or CAT scan, with a member of the pathology department present. Sixteen clinical specimens have been received; the number is steadily increasing.

The method of biopsy is relatively standard: The same basic technique is used both for internal organs including lung and viscera and for subcutaneous masses:

Procedure:

1. Sterile prep of area, (local anesthesia not essential)
2. Insert needle into mass, then withdraw plunger creating a vacuum. (Figures 1A and B)
3. With plunger withdrawn sample the tumor. Make 3-4 passes in different directions without withdrawing the needle from the tumor. (Figure 1C)
4. Release the vacuum from the syringe by slowly releasing (but not pressing) the plunger. Then withdraw the needle from the tissue. (Figure 1D)
5. Express the aspirate into the carbowax container by advancing the plunger. If no aspirate is expressed detach the needle, fill the syringe with air and advance the plunger again. If aspirate is in the syringe you may try to flush it with the carbowax solution. The specimen is a very small drop of fluid or a tiny (1 mm³) plug of tissue. Since the specimen is commonly in the barrel of the needle, it may not be visible. Abundant cystic fluid or blood should be placed in carbowax.
6. A smear is the first priority. Perform steps 2-4 and then express the aspirate onto a clear glass slide. (Figure 2A) The specimen is spread by:
 - A. Placing (without pressure) another slide on top of the first. (Figure 2B)
 - B. Allowing the slide to spread the aspirate by

(Continued on page 72)

*Dr. Preshaw is a resident in Pathology at Presbyterian Medical Center, Denver, Colorado, and Dr. Hyman is a staff pathologist at Presbyterian. Supported by a Maytag Memorial Fund grant.

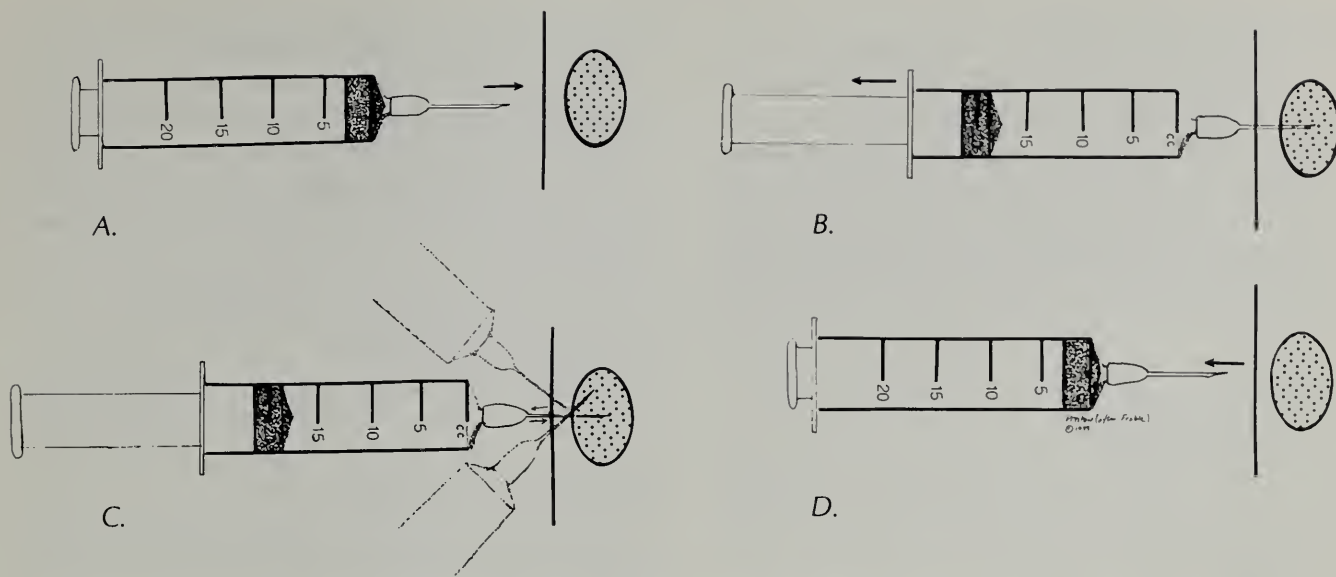


Figure 1.

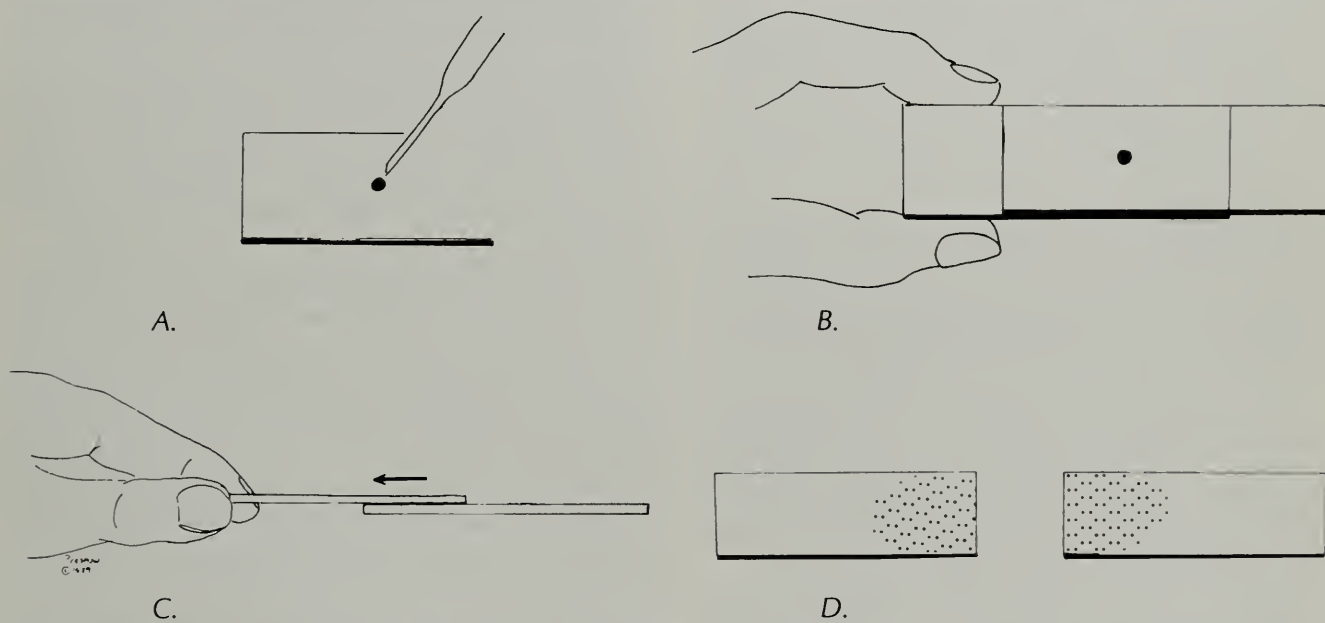


Figure 2.

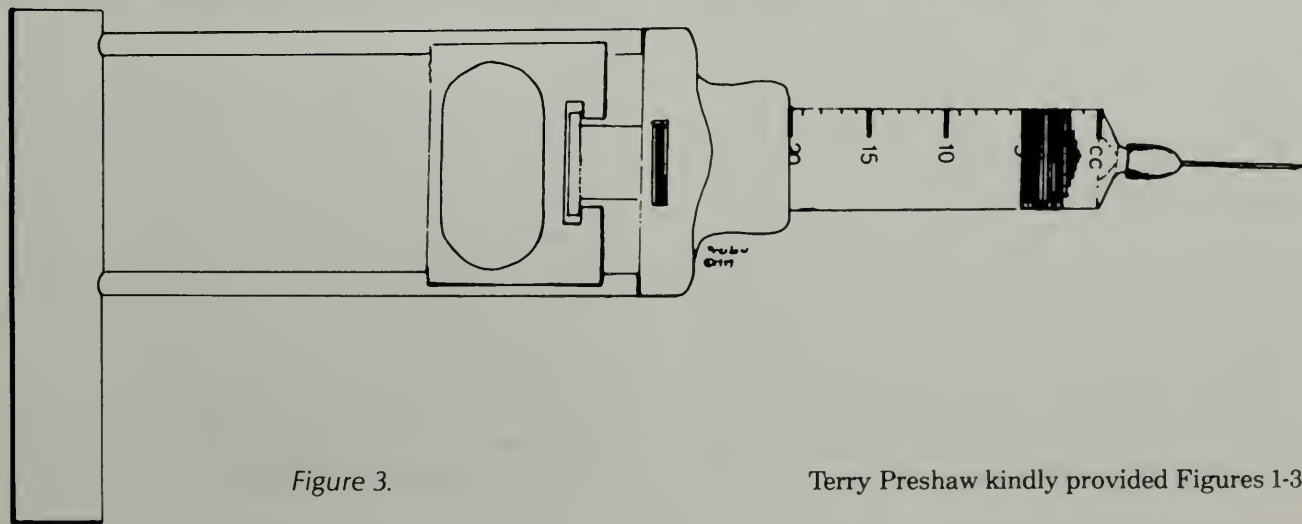


Figure 3.

Terry Preshaw kindly provided Figures 1-3.

(Continued from page 70)

gravity for about 1 to 2 seconds.

C. Pulling the slides apart without lifting, i.e., in the same plane. (Figure 2C)

Both slides are acceptable specimens (Figure 2D) and are placed in 95% methanol *immediately* (within 1 to 5 seconds). Four or five slides should be made. A slide may be placed in glutaraldehyde for immediate rapid H. and E. stain (as in a frozen section).

Materials needed:

1. 20 cc syringe
2. 22 gauge needle
3. 95% methanol in a container which will hold slides
4. 2% carbowax in 50% ethanol in specimen container
5. Alcohol, etc., prep for skin
6. Clear glass slides
7. Metal syringe pistol grip (Cameco, Precision Dynamics Corp., Calif. is one acceptable brand. (Figure 3)
8. 2.5% glutaraldehyde (optional, for electron microscopy).

A syringe holder is a useful, although usually not essential item. It allows the application of suction and control of the syringe with one hand, allowing the other to control the target mass or needle. Some have found it necessary if the target mass is less than two mm. in diameter.³

The smears are stained with routine Pap. stain and the carbowax specimen is centrifuged and processed in paraffin for H. and E. stain. Smears can even be used for special procedures such as acid phosphatase, immunoperoxidase, and electron microscopy if collected appropriately.

The aspirate is diagnosed as positive, suspicious, negative, or unsatisfactory unless special features are present. If features further distinguishing a tumor are present this is mentioned. Example: positive for malignancy, probable adenocarcinoma of ovarian origin.

Results

Biopsied surgical specimens:

Forty-five surgical specimens were biopsied. The majority were lung, lymph nodes, and subcutaneous, (see tables). All nine lung masses were correctly identified: eight were malignant and one was benign, a specificity of 100% and a false positive rate of 0%. Of 14 lymph nodes and subcutaneous tumors 13 were correctly diagnosed: five were benign and eight were malignant. The one false positive diagnosis (11%) was a thyroid

mass; A case of nodular hyperplasia of the thyroid was called papillary carcinoma.

The remaining 19 biopsied specimens included diverse tissues such as mediastinum, ovary, kidney, etc. All were correctly diagnosed except the breast masses, where three of four malignancies were missed and one case of mastitis was called suspicious.

Three specimens were unsatisfactory.

Clinical Specimens:

Sixteen specimens have been received so far and clinical follow-up has been obtained in 10 cases. No false positives have been documented but there were two false negatives.

Of four transthoracic needle biopsies of the lung, 2 malignancies (large cell undifferentiated and squamous cell carcinoma) were diagnosed. One had brain metastases by CAT scan and the other has had a clinical course consistent with recurrent squamous cell carcinoma. Of the two benign cytologic diagnoses one was a false negative but the aspiration was performed with questionable technique, at another hospital. The other pulmonary mass has regressed on serial chest xrays, and therefore is regarded as inflammatory.

Of the remaining 12 specimens one false negative case has been documented. These cases include: 1) a pancreatic mass proven to be carcinoma by percutaneous skinny needle biopsy; 2) four subcutaneous masses, two proven to be recurrent cancer; 3) two liver aspirates, one inflammatory and one adenocarcinoma; 4) one breast mass called benign on aspiration biopsy, proven malignant on histology; 5) one benign thyroid nodule; 6) one kidney mass, a metastatic carcinoma; 7) one retroperitoneal mass with cytology consistent with lymphoma; and 8) one pelvic mass, a metastatic carcinoma.

Discussion:

Thin needle aspiration biopsy is a procedure used only sporadically in the United States, although its safety and utility have been documented in many organs. Lymph nodes and subcutaneous masses are the most easily biopsied. A series of 323 cases by Dr. W. Frable at the Virginia Commonwealth University focused on aspiration of nodes from the head and neck. One hundred and ninety-three of these were cancers. He had two false positives (1%) and a sensitivity of 97% (only six were missed). The two false positives were diagnosed as "suspected lymphoma,"

which requires biopsy anyway. The results for 46 soft tissue masses and 99 salivary gland tumors were similar but there were no false positives.^{2,3} A similar study from Philadelphia also had a 95% sensitivity with no false positives in 130 cases.⁸

Intrathoracic, visceral lesions, and deep masses are located by fluoroscopy, CAT scan, or ultrasound, and biopsied by a radiologist, surgeon, or pathologist. A study of transthoracic percutaneous thin needle biopsies from Sweden included 5,300 cases in which they correctly identified 91% of malignancies with an additional 4.1% read as suspicious.

The false positive rate was 2.4%. Although 27.2% of patients got a pneumothorax only, 2.6% of these required a chest tube.¹⁵ The only recorded case (for needles this size) of an implantation metastasis in the needle track is recorded in this huge series.

Percutaneous biopsy of the pancreas under CT direction has a 70 to 80% sensitivity. A Toronto study¹² picked up 19/23 cases with no false positives and a Bristol, England¹⁴ study picked up 18/18 with no false positives or negatives. The only complication reported in either series was exacerbation of pancreatitis in one case.

The two most controversial areas in needle biopsy are breast and thyroid. Although these are safe procedures, for the pathologist they are filled with pitfalls. Architectural features are often important malignant criteria in these organs so a sensitivity of only 70-87% is not surprising. The most encouraging report comes from Roswell Park where aspiration biopsy was performed on 265 patients between 1971-1976.⁵ Fifty-one of 52 thyroid specimens were correctly identified as carcinoma. Only one benign lesion was diagnosed as carcinoma (2% false positives). No serious complications were encountered, and all cases of thyroiditis were so diagnosed. However, a similar study from Bethesda, MD⁶, had a 22% false positive rate. Nine aspirates from cold nodules were given malignant cytologic diagnoses. Of these only seven were malignant histologically. However, in older patients a clinical impression of anaplastic carcinoma should be easy to confirm by thin needle aspiration, and in most cases papillary carcinoma is not hard to read if the proper area can be sampled.

The interpretation of thin needle aspiration of the breast has problems similar to those of the thyroid. Sensitivity is 75-94% in various series and a false positive rate of 1-2.5% is reported. However, one study from Boston Hospital for

Women and Harvard Medical School¹⁷ reported an 11% false positive rate and only 16/39 or 41% of those diagnosed as suspicious were documented as carcinoma. Suspicious and malignant cytologic diagnoses included only 33/48 or 80% of the histologically proven cancers. The series included needle aspirations and nipple secretion specimens and totaled 1,792 specimens. A more promising study from Paris¹⁸ with 2772 specimens reported sensitivity of 88% with false positive of only 0.3%.

Skinny needle aspiration biopsy is a powerful technique for obtaining tissue diagnosis with a minimum of expense and morbidity which can be used by community medical centers. Major and minor surgical procedures for diagnosis can be avoided. We do not advocate routine aspiration of thyroid or breast masses as our only false positive was a thyroid lesion and all of our false negatives were breast cases. These problems are common in the literature. A series of aspirations on surgical specimens is useful to build confidence and experience with the technique. It also provides a working reference of known tumors.

- ¹ Bonfiglio, Thomas A., "Fine Needle Aspiration Cytopathology of Retroperitoneal Lymph Nodes in the Evaluation of Metastatic Disease," *Acta Cytologica*, 23:126-130, 1979.
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- ¹³ Rimsten, A., et al., "The Diagnostic Accuracy of Palpation and Fine Needle Biopsy and an Evaluation of Their Combined Use in the Diagnosis of Breast Lesions," *Annals of Surgery* 182:1-8, 1975.
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The Colorado Medical Society presents Physicians Practice Management Week

Durango

May 5, 1981

Pueblo

May 6, 1981

Denver

May 7, 1981

Greeley

May 8, 1981

Grand Junction

May 9, 1981

Ft. Lewis College
Rm. 137, Classroom Bldg.

St. Mary Corwin Hospital
Auditorium

Colorado Medical Society
Weld County Hospital
Auditorium

In Association with
Western Slope Spring Clinics

Produced by Conomikes Associates, Inc.
Directed to Physicians, Medical Office Staff,
and Medical Office Managers

• Reception and Patient Flow Techniques

8:30 a.m. - Noon

APPOINTMENT SCHEDULING CONTROL

Improving patient service
Dealing with key problems; work-ins, no-shows, cancels

Designing your own scheduling system
Modified wave techniques—they actually work!

Hourly control, daily control

Effective patient-recall systems

IMPROVED TELEPHONE MANAGEMENT

Telephone policies and how to develop them
Telephone procedures checklist—working tools for anyone answering the telephone

How to curb telephone interruptions of physicians and back office personnel

New equipment ideas

Telephone tips

FRONT OFFICE STRATEGY

Cutting down on logjams at front desk

MEDICAL RECORDS

Filing systems that work for you: alphabetical vs. numerical

Cutting down on "lost" charts

Dictation and typing tips

Active-inactive-retired records and how to handle them

ENROLLMENT FEE \$55 - Half-day Workshop

delinquent accounts

BILLING

Reducing the number of statements you send
Designing charge tickets that serve as take home statements

Point-of-service collection beats billing

The Super Bill reduces paperwork

Micro-billing saves time and money

Accounts receivable system review and checklist

INSURANCE

How to cut down on insurance processing costs

Physician education

Patient education

Use of standard insurance forms

The Super Bill: reduce insurance billing by 50%

Communicating with insurance companies

The insurance claims log: makes follow-up easy

ACCOUNTS PAYABLE REVIEW

Checkwriting systems

Invoice handling

Petty cash

Refunds

Profitable use of your bank deposits

ENROLLMENT FEE \$55 - Half-day Workshop

• Financial Control for Physicians

(Physicians Only) — 1:30 - 5:00 p.m.

BETTER FINANCIAL CONTROLS

How the physician can do a 7-minute audit to see if all charges are properly recorded

Monitoring an accounts receivable control on a daily basis

Reducing your accounts receivable

Better check-signing procedures; how to review your invoices

Controlling petty cash expenditures

Eleven points to better bookkeeping controls

Financial and productivity reporting

Daily, weekly, monthly reports: Examples

BETTER BILLING, COLLECTION AND INSURANCE PROCESSING

How to improve collections, save billing costs and improve your cash flow

Getting patients to pay for office visits when the

service is performed—and reducing your billing costs

Better collections intelligence by "aging" your accounts receivable

Making better use of your charge tickets

The Super Bill—having patients process their own insurance forms for routine office register

Monitoring your insurance claims register

Collection follow-up procedures that work

Micro-billing—saves you time and money

Time-tested techniques for collection over the phone

ENROLLMENT FEE \$55 - Half-day Workshop

I WILL ATTEND

- ☐ Reception and Patient Flow Techniques
☐ Better Collections, Billing and Insurance Methods
☐ Financial Control for Physicians (Physicians Only)

Enrollment fee \$55.00 per enrollee per half-day workshop; check payable to CMS.

Enrollee Name

Practice Address

City

State

Zip

Location of Attendance

Practice Telephone

March, 1981

20 INFECTIONS IN THE DIABETIC. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Service, 384-5412.

21-28 ULTRASOUND AT VAIL—2ND ANNUAL SEMINAR. The Lodge, Vail. Contact: Ultrasound at Vail, P.O. Box 6093, Cherry Creek Station, Denver 80206.

22-28 CLINICAL MANAGEMENT AND CONTROL OF TUBERCULOSIS. National Jewish Hospital, Denver. Contact: Thomas Moulding, M.D., National Jewish Hospital & Research Center, 3800 E. Colfax Ave., Denver 80206. 388-4461, Ext. 647. (48 hours of AMA category 1 credit; 48 prescribed AAFP hours).

25 REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE. Department of Radiology, University Hospital, Denver, 80262. Contact: Suzanne Warner, 394-7773. (3 hours of AMA Category 1 credit).

25 LEGIONNAIRE'S DISEASE: EPIDEMIOLOGIC STUDIES IN MAN AND ANIMALS. Department of Preventive Medicine, University of Colorado Health Sciences Center, Campus Box C245, 4200 E. 9th Ave., Denver 80262. 394-5177.

27 NEW ADVANCES IN DIABETES. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

28-31 RELATIONSHIPS. Ramada Silverthorne. Contact: Debbie Casselman, RMPP CCE, 1525 Josephine, Denver 80206. 321-2471. (20 hours of CME credit).

April, 1981

2 NEUROPSYCHIATRIC GRAND ROUNDS. Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

3-4 SECURING OUR FUTURE: NUCLEAR WAR AND ITS PREVENTION. George Washington High School. Health professionals and lay persons invited. For further information, call: Dr. Thomas Washburn, 861-0504 or Helen Henry, 832-4508. (CE credits available).

3 CARE OF THE PARKINSONIAN PATIENT. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

6, 13 SEMINAR ON THE BORDERLINE PERSONALITY DISORDER. Boulder Psychiatric Institute. Contact: Community Relations Coordinator, Boulder Psychiatric Institute, 4390 Baseline Road, Boulder. 447-2902. (AMA Category I credit).

7-10 THE SPORTSMAN AS A PATIENT. Keystone Resort, Colorado. Contact: Symposium Coordinator, Edgar L. McWethy, Jr., USAR Center, Bldg. 820, Fitzsimons Army Medical Center, Aurora, CO 80045. 341-8045/3096. (10 hours of AMA Category 1 credit).

8 HEALTH EFFECTS OF WHOLE BODY RADIATION DURING DEVELOPMENT IN THE BEAGLE DOG. Department of Preventive Medicine, University of Colorado Health Sciences Center, Campus Box C245, 4200 E. 9th Ave., Denver 80262. 394-5177.

9 PEDIATRIC EMERGENCIES. Estes Park. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

10 ANKYLOSING SPONDYLITIS. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

13 MOST COMMON ERRORS IN ALLERGY AND HOW TO CORRECT THEM. Burlington. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

16 G.I. BLEEDING—EMERGENCY DIAGNOSIS AND TREATMENT. Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Ave., Denver 80203.

17 PSYCHOSOCIAL ASPECTS OF AGING. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

22 REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE. Department of Radiology, University Hospital, Denver 80262. Contact: Suzanne Warner, 394-7773. (3 hours of AMA Category 1 credit).

board of directors condensed minutes

HIGHLIGHTS, CMS BOARD OF DIRECTORS MEETING, FEBRUARY 20, 1981

1. Approved concept of CMS/CFMC working more closely and Colorado physicians being more aware of the Foundation's activities and goals. A joint meeting of the Boards will be scheduled to discuss this relationship.
2. Approved request from DR. BRITTAIN (MLCP) to offer the University of Colorado Health Sciences Center regular, on-going risk management programs with residents.
3. Approved charges and responsibilities of the Risk Management Committee.
4. Approved conceptually a proposal for the development of two premium structures for the professional liability insurance program.
5. Disapproved concept of reduced professional liability insurance rates for new practitioners.
6. Received recommendations from Medical Executives Group (MEG) to: a. change dues billing process schedule; b. revert back to calendar year for CMS membership year; c. establishment of a task force to look into the effect of government deregulation and the impact of price competition upon the practice of medicine.
7. Approved resolution to AMA requesting reconsideration of the PSRO action taken at the last meeting.
8. Adopted legislative policies based on Council on Legislation recommendations re current legislation.
9. Unanimously approved presenting a revised CMS organizational structure to the House of Delegates.
10. Authorized plans of Committee on Physician Health and Rehabilitation subject to an interpretation of recently developed BME Mandatory Reporting requirements.
11. Approved concept of Medicolegal handbook for CMS members. Funding and distribution was referred to staff.
12. Approved Warren & Sommers, Inc., sponsorship of a reception during the Interim Session for members of the House of Delegates.
13. Received a report from DR. JOSEPH POYNTER, Chairman of the Building Committee. Committee is looking at building sites and funding mechanisms. Specific recommendations should be available for the April Board meeting.
14. Received progress report regarding the feasibility study for the professional liability insurance program for CMS.

MEMBERS PRESENT:

President: K. Mason Howard
President-Elect: Frederick A. Lewis, Jr.
District I: David E. Bates, Merlin G. Otteman
District II: Jerry J. Appelbaum, William E. Jobe,
Joel M. Karlin, Anthony J. Palmieri,
Joseph H. Poynter, W. Gerald Rainer,
Edward A. Rhodes
District III: J. Richard Brusenhan, Amilu S. Martin
District IV: Malik M. Hasan, Jan S. Hildebrand
District V: Robert F. Linnemeyer, Tullius W. Halley
Immediate Past President: Ray G. Witham
Executive Vice President: R. G. Bowman

Rocky Mountain Nursing Issues Aired at National Commission Hearing

(Reprint from NATIONAL COMMISSION ON NURSING)

DENVER - March 2, 1981 - The national nursing shortage, its causes and some proposed solutions, were aired March 2 at a public hearing by the National Commission on Nursing in Denver.

Approximately 200 persons heard more than seven hours of testimony by nursing service administrators, nursing educators, administrators, physicians, government officials and staff nurses.

"The population of this country is getting older, and the demand for nurses is going to be greater, not less," said Gail Warden, executive vice president of the American Hospital Association, expressing the Commission's concern for the nursing shortage.

A Montana official quoted a study of the nursing shortage in that state and the reasons, in order of importance, were: lack of job opportunities for spouses, increased job frustration, lack of community resources, overall decrease in the number of nursing schools and the pressure of combining full time employment and family.

William E. Leary, president of the Montana Hospital Association, cited other reasons from the survey as the decrease of diploma schools, increased opportunity for women in other industries, lack of advancement for beginning registered nurses, inadequate salaries and benefits, and lack of opportunity to use training on the job.

Concerning nursing education, several witnesses stressed the need for a balance among classroom teaching and clinical training.

"I am concerned about the lack of clinical experience exhibited by today's nursing graduates," said Marilyn White, R.N., Director of Nursing for Missoula, Montana, Community Hospital.

"Six months ago I interviewed still another graduate who had never catheterized a patient during her four years of training," said Ms. White, who advocated closing the reality gap between classroom theory and practical experience.

Solutions to increase job satisfaction were offered by Luis C. Silva, administrator of La Plata Community Hospital in Durango, Colo., who said his hospital has developed a recognition program, encouraged continuing education, established a new employee orientation program, and represented nurses on hospital committees and boards.

The National Commission on Nursing is a 29-member group that reflects the first national coalition effort of representatives from the field of nursing, medicine, hospital management, government and academia. The coalition is seeking solutions to the problems related to the nursing profession in the 1980s and beyond.

The information gathered at the Denver hearing, the fourth of six hearings nationwide, will be used to develop recommendations to be made public next September in published form.

Speakers Bureau of AMA to Coordinate 1981 Awards Program

The AMA Speakers Bureau is coordinating the fourth annual national competition for physician-speakers who represent their medical society in various categories. This program was designed to improve the overall effectiveness of persons speaking on behalf of medicine and to stimulate more consciousness in the Federation for better communication skills in speakers bureaus, meetings and testimony.

The CMS Division of Communications will soon be publishing the ground rules for entering the competition, and Component Societies are urged to contact this division for aid in such entries, or programs leading up to entry in the competition.

CONFERENCE ON HEALTH CONCERNS OF WOMEN

sponsored by the COLORADO MEDICAL SOCIETY

in cooperation with

Colorado Medical Society Auxiliary
American Medical Women's Association, Colorado
Colorado Federation of Business & Professional Women
Colorado State Division of the American
Association of University Women
Colorado Parent, Teacher, Student Association

Colorado Federation of Women's Clubs
Colorado Church Women United
The Delta Kappa Gamma Society International,
Colorado State Organization
Colorado Hospital Association Auxiliary
Colorado Federation of Nurses
Colorado Nurses' Association

- A conference offering the chance to discuss health concerns with doctors, nurses, professionals
- Saturday, May 9, 1981, Thomas Jefferson High School, 3950 South Holly, Denver
- Seven workshop discussions offered in the morning, repeated in the afternoon
- **Registration is limited, confirmed reservations are non-refundable**

Program: 8:30 a.m. - 4:30 p.m.

8:30 a.m. Registration

9:00 a.m. **Women and Health**

K. Mason Howard, M.D., Pres.
Colorado Medical Society

9:20 a.m. **Colorado's Program for Combatting
the Costly 5: Stress, Obesity, Alcohol,
Drugs, Lack of Exercise:**

Frank Traylor, M.D., Exec. Director,
Colorado Department of Health

—Audience Participation—

10:00 a.m. Light refreshment break

10:30 a.m. **CONCURRENT WORKSHOPS**

Noon Lunch—demonstration of aerobic dance
and stress management techniques

1:30 p.m. **CONCURRENT WORKSHOPS REPEAT**

3:15 p.m. Workshop reports: summarizers' reports
and discussion

4:00 p.m. **Future Directions:** Mildred Doster, M.D.,
Concluding talk and discussion

CONCURRENT WORKSHOPS: 10:30 a.m. and 1:30 p.m.

(Please select two workshops)

New insights on your personal health concerns: panel presentation followed
by discussion. Workshop subjects and some presenters include:

1. **Women's Rights and Responsibilities as Patients:** issues of patient-doctor communication, sensitivity to women's health needs—Libby Bortz, psychiatric social worker, college instructor in behavioral science & women's studies.
2. **What, Why and How of Our Hormones:** the need to know about our bodies—Mabel Christine Brelje, M.D., gynecological practice with prime focus on patient education and preventive care.
3. **It Pays to Keep Fit:** the real facts of health enhancement—Mary Jo Jacobs, M.D., a physician who promotes fitness with programs for patients who strive to maintain health.
4. **Maintaining Health during Pregnancy and Child-birth:** healthy pregnancy, genetic counseling, alternative settings for childbirth, birth control—Eve Hoygaard, R.N., parent education director in hospital maternity department.
5. **Health in the Middle Years and Beyond:** issues of menopause, hormonal therapy, health assessment and mental health—Frank McGlone, M.D., specialist in geriatric medicine.
6. **Women, Alcohol and Drugs:** drug misconceptions, prescription drug abuse, the availability of services for women—Franklyn M. Newmark, M.D., specialist in treatment of alcoholism and drug abuse.
7. **Coping with Our Changing Roles:** stress, depression, and the impact of changing roles on women's emotional health—Helen Gerash, M.D., psychiatrist and mother of two.

REGISTRATION DEADLINE: April 30, 1981

PLEASE MAIL REGISTRATION TO:
Colorado Medical Society Women's Health
1601 East 19th Avenue
Denver, Colorado 80218

REGISTRATION FORM

Name _____ Telephone _____

Address _____
Street City State Zip

Workshop Preference: My 2 choices for workshops are:

Workshop # _____

Workshop # _____

Registration Fee: \$7.50

Fee includes morning refreshment and lunch. Please make checks payable to Colorado Medical Society. Confirmed registration is non-refundable.

standards of practice

(Continued from page 61)

must be outlawed. The express inclusion of those three weapons implies that others are not to be outlawed. This does not prevent my arguing that swords are also dangerous weapons and that the legislature could have exempted swords if it wished, but failed to do so. However, the stronger suggestion is that the specific mention of certain weapons implies that others (swords) were not meant to be covered.

Ejusdem generis is a rule that where general words follow enumerations of particular classes or persons or things, the general words are construed as applicable only to persons or things of the same nature as those enumerated. *Gifis, Law Dictionary* Barron's Educational Series, 1975. Thus, if a statute allows chiropractors to "manipulate, massage, apply heat and take other necessary physical measures," the "other necessary physical measures" may be construed to mean only non-surgical measures. More narrowly, it might mean only measures by hand.

SAFETY SECTIONS

"A practice which is somewhat unusual, although not limited to Colorado, is the almost automatic inclusion of a so-called "safety clause" in every bill. The clause is always set out as a separate section and states, in brief that the legislature finds that the Act is necessary for public peace, health, and safety. It has, as its purpose the prevention of a referendum on the measure, since Article V, Section 1 of the Colorado Constitution provides that laws necessary for public peace, health and safety are not subject to referendum and the Colorado Supreme Court has held that a finding of these facts by the legislature is conclusive. Thus, there exists the absurd situation in which the legislature solemnly declares that an act permitting the state to sell a few acres of land is necessary for the immediate preservation of public peace, health and safety and having said it, no one can deny it."—A. Menard, Jr., *Legislative Bill Drafting*, 23 *Rocky Mtn. L. Rev.* 127 (1950).

Until the Al Ullmans disappear, legislature-made law is just as difficult to apply as common law. Perhaps it is more difficult, lacking the years of interpretation and refinement that is the strength of common law. But a few rules of construction, properly applied, make everyone's job easier.

—Brian Stutheit
Colorado Medical Society

book corner

Protocols for Pre-hospital Emergency Medical Care: Jean Abbott, MD, Marilyn Gifford, MD, Clark Chipman, MD, Joseph Engelke, MAPA, and Peter Orsen, MD. Williams and Wilkins, Baltimore, 1980. 191 p. \$9.95.

Protocols for Pre-hospital Emergency Medical Care by Jean Abbott, Marilyn Gifford, Clark Chipman, Joseph Engelken and Peter Rosen reflects the "state of the art" field management guidelines to be used by EMT's in emergency medical systems. While it is designed to offer the specifics of such field protocols, it is a compendium of the therapeutic philosophy underlying this rapidly expanding aspect of emergency medicine itself.

Historically, the development of contemporary pre-hospital care systems parallels the growth of emergency medicine. The past decade has witnessed an asymptotic expansion of emergency medical services, culminating in the formal recognition of emergency medicine as a specialty. No less specialized is the provision of sophisticated care in the field prior to the arrival of the patient in the emergency department. While pre-hospital care has existed in one form or another since ancient times when the predecessors of "EMT's" braved all manner of implements of destruction and weaponry to remove their fallen kin from the battlefield, the impetus to develop modern field management techniques is emergency medicine itself.

The growth of pre-hospital care systems derives in large part from the frustration experienced by emergency physicians who viewed the oftentimes primitive evaluation and transport of their patients who could then not be salvaged, despite the gleaming technical advances and skill possessed by the physician within his institution.

Pre-hospital care constitutes a sub-specialty within a specialty. Cultivated by local emergency medicine physicians and nurtured with federal E.M.S. dollars, it has grown to be a highly technical, innovative and complex field.

The EMT is the direct extension of the physician, the ambulance is his medium and the field his arena of practice. The physician provides the legislative breath of life for the EMT. Though the latter performs as the immediate provider of field care the responsibility for the quality of that care remains with the physician. Defining the protocols by which field care may be administered constitutes one of the single most important aspects of any pre-hospital care system. To this end this book has addressed it.

(Continued on next page)

book corner

(Continued from previous page)

self. "Protocols for Pre-hospital Emergency Medical Care" represents the culmination of more than two years of intensive work by the authors, all deeply committed to emergency medicine. With strict admonitions to "optimize pre-hospital care standards for their particular locale" the authors have placed before E.M.S. physicians, an assortment of protocols which may serve as the fundamental models for specific adaptation to the requirements (and skill level) of the pre-hospital care system at the local level. For the physician advisor (the physician who must authorize as well as assume responsibility for the actions of pre-hospital personnel) the manual provides firm guidance in this task. For the EMT, it provides the standards to which he or she must adhere and defines the knowledge base as well. For the interested non-emergency physician it offers an opportunity to observe the advances and capabilities of the field, barely a decade old whose early counterparts routinely did double duty as the town morticians. Designed as a reference source, the book addresses the above audience quite successfully. As the physician advisor for a major urban paramedic system I found its chapters to represent the standards by which other manuals will be judged. The book is designed for easy reference, and to that end, is compiled in a size which makes it suitable for field personnel.

Norm Dinerman, MD
Denver, Colorado

Spotting the Addict

It happens to all doctors eventually—a "patient" tries to con you out of drugs. Here are some of the more common stories drug users tell:

- I'm new to town.
- I'm allergic to that drug I need Dilaudid (or Percodan).
- I get migraine headaches.
- I have kidney stones. See, there's blood in my urine.
- I can't go to the hospital for more tests.
- I do have these old x-rays.

What to do?

- Look for needle marks on hands, wrists and arms when you check blood pressure.
- Prescribe only a few tablets to new patients requesting analgesics, hypnotics or diet pills. Start new patients with mild drugs—addicts will usually try to talk you into a stronger drug and more pills.
- Keep your prescription order forms in your pocket, not on your desk or in examining rooms. Report thefts promptly.
- Have your receptionist ask new patients with pain or overweight complaints for photo ID to verify their names and addresses.
- Report suspicious incidents to the police promptly. The addict you prescribe for today will pass forgeries on your order forms knowing that when a suspicious pharmacist calls to verify the prescription, you will say "yes, I prescribed that", not knowing the pharmacist is actually holding a forgery. People in real pain will fill their prescriptions promptly, not hours or days later!

Did you know that a 4 mg. Dilaudid tablet which costs about 25¢ at the pharmacy sells for \$30.00 on the street? Forgery, faking illnesses and pain and "doctor shopping" (going from doctor to doctor with the same symptoms) are big business. Stop prescription fraud by developing the reputation of turning addicts away.

Impaired Physician Program Begins Operating

The Physician Health and Rehabilitation Committee has held an initial Advocates Training Session, and has developed guidelines for the CMS Committee to assist physicians with impairments such as drug and alcohol. The CMS Board of Directors has approved of the Committee's administering the program for voluntary assistance and treatment of impaired physicians.

If you wish to become an advocate or make a referral, please contact Virginia Bell at the CMS office in Denver: telephone 861-1221 (WATS line 1-800-332-4150).

The name of a physician may be referred to the Committee with the confidence that, before any assistance is initiated, there will be careful investigation and verification of impairment. The privacy and dignity of the referred physician will be strictly maintained.

MAYBE YOU AND THE EMPLOYEE YOU NEED ARE LOOKING IN DIFFERENT DIRECTIONS.



That top-notch person you want may be ready to make a change, but neither of you knows about the other. That's where the professional personnel consultant comes in. We put good people and good positions together.

A personnel consultant:

- knows where to find the right people. Often, they come to us first.
- screens applicants' skills, experiences, and personal backgrounds in advance.
- sends you qualified applicants for interviews and keeps sending them until you're satisfied.
- charges only when you hire.

Personnel Consultants Put People And Positions Together.

MEDICAL PLACEMENT SERVICES
2020 Wadsworth Blvd., Suite 15A
Lakewood, Colorado 80215
(303) 232-8604

Shirley M. Kukral

A member of the National Association of Personnel Consultants



(Continued from page 61)

plans in the nation. It has been designed by members of the medical profession to be offered exclusively for the doctor, his/her family, and employees. The benefits and rates reflect a substantial savings and increased coverage applicable to the medical profession today.

Doctors have traditionally been lumped into the so-called "boiler plate" programs with rates and coverages applicable to groups other than the medical profession. Careful study and experience has shown the rates previously charged doctors and their employees are figured at a rate higher than actually necessary.

The experience of the participants in the CFMC Trust has been excellent over the years, causing little adjustment in rates and constant attention to increased benefits in those areas where the need has indicated. The Foundation, as Claims Administrator, has been able to constantly monitor the plan and give direction where indicated.

The Colorado Foundation for Medical Care, because of its excellent staff and claims handling experience, has eliminated most of the problems found in others plans and has been able to provide to the doctor a service utterly free of worry when a claim arises. Not only does a program run smoothly when this service is provided, but an up to date communication system is constantly monitored between the doctor, hospital, pharmacy, and service agencies.

Since this coverage has been designed as a group plan, there are no physical examinations required when a group of 6 through 10 enroll 100% of eligible participants, or groups of 11 through 49 have 75% of the eligible participants enrolled. The new life rates, which should be approved shortly, have even more liberal underwriting.

Such benefits as room and board are 100% of average semi-private. Covered hospital expenses are 100% for the first \$1,000, then 80% to \$5,000, and back to 100% up to the plan maximum of \$250,000. Surgery, anesthesiology, and medicine have been increased to meet today's factors. These are just a few of the highlights of a plan that is first and foremost our plan, reflecting what we feel are more advantageous rates to the medical profession.

The Administrator of our plan is the Cooney Agency who, as our representative, is responsible for negotiations with the carriers at our direction. They are located at 1922 East 18th Avenue, just several blocks from the Colorado Medical Society's headquarters. For information concerning the insurance programs being offered to either CMS and/or CFMC member physicians, please contact The Cooney Agency, at 388-0854, collect.

—Arja Adair

(Continued from page 62)

Bunnell, at the Colorado Consortium for Continuing Medical Education (Colorado Medical Society), at 861-1221.

Kevin Bunnell, Ed.D., Director, Division of Continuing Education and Public Health, Colorado Medical Society.

High Altitudes Blamed In Eye Hemorrhages

CHICAGO—Skiers, hikers and mountain climbers who mount rapidly to great heights risk eye injury from small hemorrhages under the surface of the eyeball.

Further studies on this medical event are reported in the Feb. 13 Journal of the American Medical Association from scientists in a laboratory on the summit plateau of Mt. Logan in the Canadian Yukon, at 17,500 feet.

Thirty-nine healthy men and women were examined before and after a stay on the Mt. Logan facility. More than half had hemorrhages in the retina of the eye and one showed "cotton-wool spots".

The eye hemorrhages were more frequent during

strenuous exercise, and more frequent among those who reached the high altitude quickly. Those who climbed slowly up to Mt. Logan had fewer eye bleeding episodes.

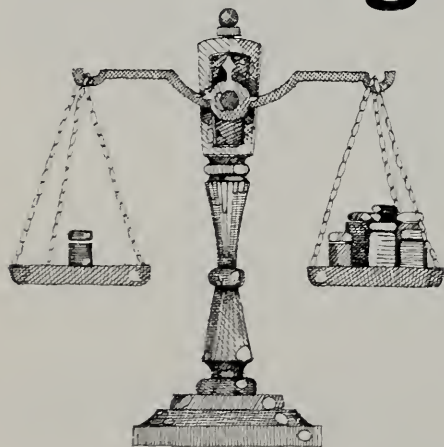
Most common damage consisted of multiple flame-shaped hemorrhages, but "dot and blot" and other types also were seen.

The hemorrhages in the eye are the result of the lower oxygen content of the high air. This brings a large increase in volume of blood flow to the eyes in an effort to compensate for reduced oxygen in the blood. The extra rush of blood sometimes brings small ruptures under the surface of the eye.

Usually the eye hemorrhages caused no permanent damage, clearing up without treatment. For the most part they are not sufficiently serious to require the climber to descend. There is, however, one type of altitude-induced eye hemorrhage that interferes with vision. If this occurs, the climber should go to lower elevations quickly.

The report is from a group headed by D. Murray McFadden, M.D., of the Arctic Institute of North America, Calgary, and the Department of Ophthalmology, the University of British Columbia, Vancouver. Charles S. Houston, M.D., of the University of Vermont, Burlington, was the American doctor with the Canadian research team.

Weigh it for yourself...



An ounce of prevention is still worth a pound of cure!

A vital part of staying healthy, is taking good care of yourself, eating the right foods, getting exercise and enough sleep and dealing with minor medical problems before they become major ones. Preventative medicine will certainly help, but unexpected accidents or sicknesses can happen to anyone. And when that happens, you not only

face the problems of the sickness or injury itself, but the financial burden which often results.

To help keep your financial picture healthy, the Colorado Medical Society endorses Disability Income Protection for its members. This plan can provide you with a regular monthly benefit when a covered sickness or injury keeps you from your practice. You can use your benefits any way you choose — to buy groceries, make house or car payments or provide for your children's education. And Disability Income Protection, underwritten by Mutual of Omaha, is available to members of the Colorado Medical Society at Association Group rates.

For complete information on how you can help protect your financial future, mail in the coupon or contact the Mutual of Omaha representative nearest you for personal, courteous service.

Tony Occhiuto
2950 N. Academy Blvd., Building D
Colorado Springs, CO 80907
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obituaries

Doctor S. Alexander Briggs II died at his home on December 25, 1980, after an illness of a year. He was 37. Born in Cambridge, Massachusetts, on June 22, 1943, Briggs attended schools in Lincoln, Massachusetts, and St. Lawrence University in Canton, New York. He received his medical degree from the University of Colorado.

Briggs, who lived at 3201 E. Seventh Avenue in Denver, was a member of the Colorado Medical Society, the Denver Medical Society Board of Certified Anesthesiologists and Diplomats of the American Board of Anesthesiologists. He served in the Army in Korea and joined the Navy in 1972, working as an anesthesiologist. Most recently, he conducted a private practice in Denver.

Doctor Briggs married Margaret Stewart on February 25, 1967, in Lincoln. Surviving, in addition to his wife, are two daughters, Kristin and Jennifer Briggs, both of Denver, his father, Sheldon A. Briggs of Cambridge, his grandmother, Hazel Sears of Dalton, Massachusetts, and a sister, Donna D. Briggs of Brookline, Mass.

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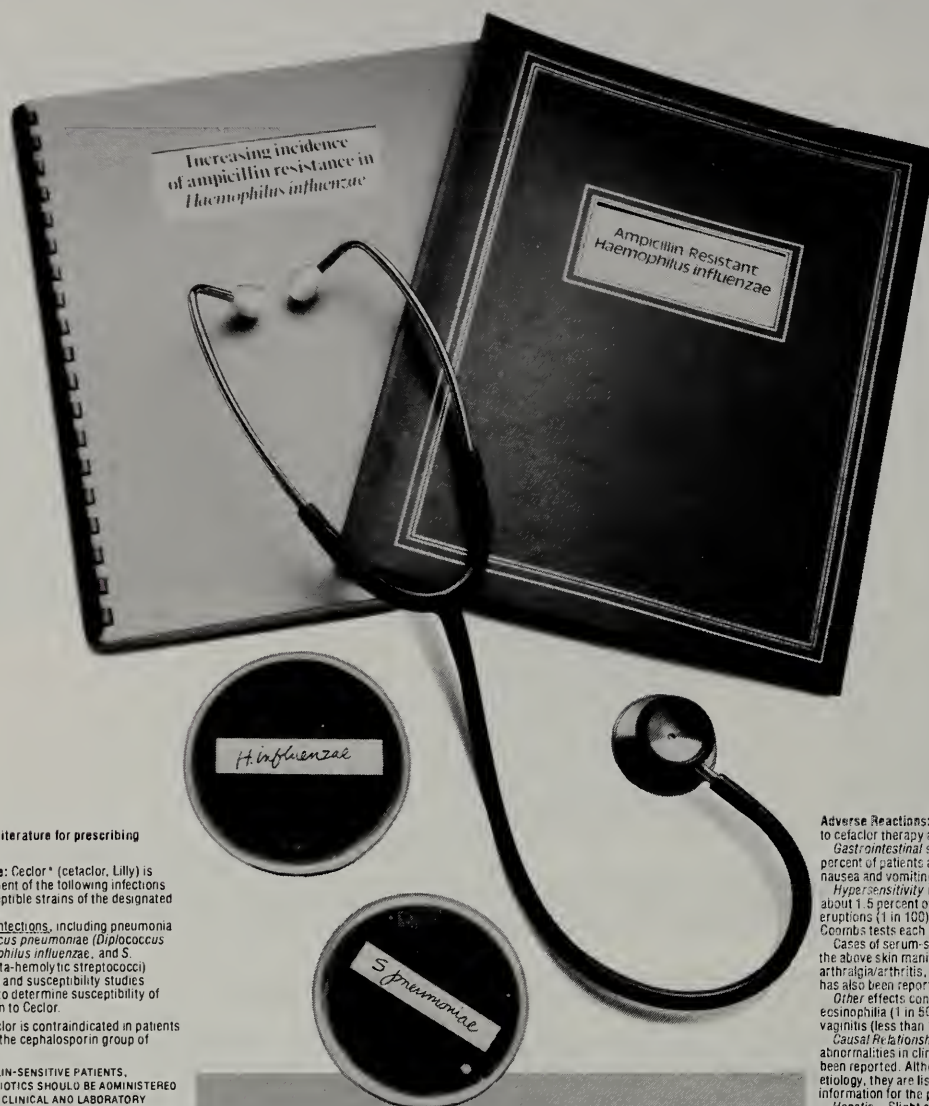

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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cefclor

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Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below:

Gastrointestinal: Symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 30).

Hypersensitivity reactions: Have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects: Considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [1030808]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1979.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Segenhaler and R. Luthy), II: 880, Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

100061



April is covered by "HEALTH POWER," that identification of our state-wide effort to aid in patient self-responsibility and public health information. Inspired by the designs created by the CMS Auxiliary and expanded into a total campaign of health information, including radio, television, newspapers and

magazine publication, "HEALTH POWER" becomes increasingly important with this issue, as is detailed in our cover story in the "... AT PRESS TIME" section, beginning on page 89.

articles

111 Radiation and Rocky Flats in Perspective

D.C. Hunt, PhD, T.R. Crites, PhD, C.R. Lagerquist, CHP

The last of a Series of articles written and submitted by the health specialists of Rockwell International, Energy Systems Division, operators of the Rocky Flats Nuclear Weapons Plant, Golden, Colorado.

115 Dermabrasion: An Effective Treatment for Acne and Its Aftermath

Brenda Hume, BA, Fort Collins, Colorado

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117 Surgery for Morbid Obesity: Comparison of Gastric Bypass with Vertically Stapled Gastroplasty*

Gifford V. Eckhout, MD, and J. Frederick Prinzing, MD, Denver

Surgery developed in the past twenty years because of a failure of medical management in the vast majority of patients.

*From the Department of Surgery, St. Joseph Hospital, Denver, CO

123 Preoperative Psychiatric Evaluation: Gastric Exclusion Surgery for Morbid Obesity

Clyde Stanfield, MD, Denver, Colorado*

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*Assistant Clinical Professor of Psychiatry, University of Colorado Health Sciences Center and St. Joseph St. Luke's Hospital, Denver, Colorado.

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127 Beer Drinkers Assured Freedom from Cancer Fear

AMA researcher puts dollar equivalent on amount of nitrosamines in beer, which makes amount look exceedingly small ... less than pocket change.

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Health Power!

Yes, it's been a while since you've seen anything of "HEALTH POWER," but it is still very much with us. This month marks the beginning of a totally new effort to "go public" 100% with this campaign for Colorado Medical Society and the CMS Auxiliary.

In case you've forgotten, Health Power was originally conceived by the CMS Auxiliary members in 1979, and sprang into being during March, 1980, when Governor Richard Lamm and other state and local leaders proclaimed March as "Health Power Month." The campaign faltered, in some respects, because there just wasn't enough "horse" power to go round. The Public Information Committee did, however, tacitly agree that the Health Power theme could be used as a Society-wide theme for the promotion of patient responsibility and health education. The CMS Auxiliary developed a pamphlet which was highly successful and extremely inexpensive to produce and distribute. The pamphlet promoted the "seven good health habits your physician wants you to have." Through cooperation with Burroughs-Wellcome Company representative George Vardaman, a series of radio programs was commenced. These programs are based on a five-minute interview format, dealing with all variety of health subjects. We're still producing these programs, but they have never been put on the air on a regular schedule because of quality problems. These problems have now been solved, and the series will begin on Colorado stations within a matter of weeks after this article goes to press. Our television spots did not materialize because we just didn't have the equipment or the manpower to put them together and distribute them. The newspaper articles which were planned for once-a-week publication were held back because of lack of uniform agreement to the subject material and specific handling of information.

Now, it's 1981, and all of those above-mentioned shortcomings have been corrected, and the strengths of the program have been re-amplified. Here's what's happened:

The Colorado Medical Society Auxiliary has produced a pamphlet again this year, changing the emphasis of Health Power to "HEALTH POWER IS A FAMILY AFFAIR." The new pamphlet is a knockout, and we already have 75,000 committed to print. They will be available this year to whomever wishes to distribute them in offices, clinics, waiting rooms, mail stuffers and paycheck envelopes. The cost is low: Member-physicians can obtain these pamphlets in quantities of

one-hundred at no cost. Over one-hundred, the cost will be 1/3 cent each, plus postage. We are still receiving requests for last year's Health Power pamphlet, so this year should really be successful because it is even better. Again this year, the pamphlet will be distributed in such public places as super markets and public gatherings, but that is only a part of the audience. There is ample space on the pamphlet so that you can add your own office name and stamp. We urge you to do so, because this pamphlet has to represent you, the physician.

CMS Communications has already produced the first three of a series of television announcements promoting the good health habits. These 30-second spot announcements, hopefully, will be in broadcast schedules by the time this magazine reaches you. The production of these announcements will be an on-going project; they are designed to help your patient-physician relations, so they are important. Your comments and participation concerning future announcements are solicited.

We are now working on the finalization of the radio program series, so that these programs will be distributed in packages of 13 programs to whatever radio stations wish to carry them. The quality of the programs is now high enough to meet the requirements of any Colorado radio station, and once they are in the broadcast schedules of the stations, they are designed to continue every week, throughout the year, ad infinitum. We also need your individual support and involvement in this series of programs. When you, the physician, see the appeal in this magazine for your participation, please make it a part of your plans to be interviewed and be a part of this total health-promotion program. We have a number of stations which are ready to take these programs, when we can assure the necessary quality, so the job is already done, to a large extent.

At the present time, CMS is cooperating with two component societies in producing and broadcasting programs on two Denver radio stations, and will soon be working with two other stations. The series, entitled "SPEAKING OF MEDICINE," has been well received, and is typical of what CMS can do in helping the component societies to produce their own, local radio programs with local physicians. You'll be hearing more about this in a total communications-aud packet which is going out to all component offices.

CMS is continuing to work with KMGH-TV, McGraw-Hill Broadcasting, in Denver, in production of the "MEDICALINE" program series, and we hope to

(Continued on Next Page)

DISTRICT V - 18 Delegates

DELTA - 1 Delegate

(D) Bennett, Robert J., Jr. (1-2)

LA PLATA - 3 Delegates

(A) Grenoble, David C. (1)
(D) Davis, Telford A. (1-2)
(D) Gaughan, Lawrence (1-2)

MESA - 6 Delegates

(D) Huskey, Marlan (1-2)
(D) Painter, M. Ray (1-2)
(D) Moran, Patrick (1-2)
(D) Nelson, Kenneth E. (1-2)

MONTELORES - 1 Delegate

None Present

CURECANTI - 2 Delegates

(D) Tarr, John S., Jr. (1)

MOUNT SDPRIS - 3 Delegates

(D) Jacobs, Mary Jo (1-2)
(D) Kirk, Rodney E. (2)
(D) Smith, E. J., Jr. (2)

NORTHWESTERN COLDRADD - 2 Delegates

(D) France, David W., Jr. (1-2)

* Substitute Alternate appointed to fill a vacant seat

** Additional Delegate approved by Constitution, Bylaws and Credentials Committee

1 - Attended first meeting of the House of Delegates

2 - Attended second meeting of the House of Delegates

The Value of Volunteering

"If you don't get paid for it, it doesn't count." I'm sure we've all heard this comment or something very similar at one time or another. In today's money-oriented society, a person's worth is frequently judged by the amount of money he/she earns. (Women are encouraged to find jobs and often those fortunate enough to be able to stay at home feel inferior or less valued than their "working" counterparts.) A paycheck becomes a standard of value, both to the wage-earner and to the outside world.

Volunteer activities are not always accorded the attention and consideration deserved, but without these efforts our society would be much poorer. How do we measure the value of an afternoon spent teaching 3rd graders about animals whose very existence is threatened by pressures on our environment? Or the value of driving a shut-in to the hospital or doctor's office for treatment? Can we....better yet.... should we, put a dollar value on the hours spent studying art appreciation so our knowledge can be shared with young and old at the art museums?

The experience gained in volunteer activities is not usually counted on a job application, but the person who has been PTA President has a wide range of management skills, and most Scout leaders have developed an amazing array of "coping talents." Almost any aptitude, interest or area of concern can be expanded through involvement in a volunteer activity.

And what are those personal rewards of volunteerism BEYOND helping those around you? In two words: SELF-HELP!

This nation's top career counselors and consultants will tell you repeatedly that if you are a housewife and not employed outside the home, or if you are in that "fortunate" position of not having to be gainfully employed, you should pay yourself by volunteer activities, particularly where you can make use of your experience and professional or career skills. This will keep you

vital and in tune with the job market in your own skill area. Say you are experienced in secretarial skills: If you can put these skills to work for a worthwhile community project, you'll help yourself by staying "tuned up" for any job opportunity now or later. You're not giving away your talents for nothing; you're helping a person or an organization which probably can't pay for these services, and you can make them so much more effective.... AND very appreciative of your talents. Even if you don't plan to apply for a paid position in your field, what's wrong with sharing your talents just to keep in practice?

If you are unemployed, and are actively looking for a job, try volunteerism: your becoming involved in your particular job field will actually help you land that job because you'll emerge from the "unemployment shell" and people will realize you are worth their help in getting the job you want. There's no better way to prove your worth than to demonstrate it in a job, whether it be a volunteer OR a salaried position. Try it! you'll be helping yourself just as much as the person or organization you're volunteering for.

Being an effective volunteer requires dedication, patience, and a real sense of commitment to doing a job well, but the rewards in terms of self-satisfaction and personal growth can be enormous. Dollars are not an adequate yardstick for the benefits gained, both by the volunteers and the community.

Do we want a society devoid of "Pink Ladies," Big Brothers and Big Sisters, room mothers, political block-workers, consumer advocates, legislative monitors, helpers for the disabled? If we do not, then it is time for us to rearrange our sense of values, before volunteers become an endangered species.

Jan Holman
Physician's Wife
Colorado Medical Society Auxiliary, Denver

An Interesting 'Aside' to Daily Medical Issues

The local chapter of "Scalpel and Tongs," a philatelic group dedicated to the collection of postage stamps commemorating health and medicine subjects, wants you to be aware of their existence. In these days of greater interest in philately, you can find a motherlode of kindred spirit in the "Scalpel and Tongs" group. If you would like to have more information about the group's activities, contact Bob Gornig (Colorado State Department of Health) at 985-4116 or 320-8333 (office).

For those of you who are of a generic philatelic interest (plain ol' stamp collectors), you have a valuable resource available to you in the person of Jim Briarton at the Philatelic window of the Main Post Office, 19th at Stout Street. Jim is usually involved with stamp shows in the Denver area, and is loaded with information about all sorts of special-interest stamps.

First Degree Shortage area. DRS. TEDRICK and BUCHANAN, area physicians, were contacted by cms staff. DR. PAINTER said these two physicians felt that yuma county was a high need area and that they support the use of a national health service corps physician in yuma county. DR. PAINTER said the federal office in baltimore was contacted to extend the cms comment date, and that the board will have until march 17, 1981, to submit its decision. there is no fiscal impact to cms for supporting this shortage classification. the board approved of the designation.

Review of Actions by CMS House of Delegates Interim Session March 14-15, 1981 Sheraton, DTC

The Interim Session of the House convened on time Saturday morning, March 14, 1981, and several housekeeping matters were addressed by Speaker of the House, Richard Bedell, MD, before addressing the business of the session. Proposed resolutions were referred to seven Reference Committees during this morning session.

The House heard a report from CMS Auxilliary President Kathy Thompson (Fort Morgan) concerning the activities of the Auxilliary during the past eleven months of Ms. Thompson's administration, and the programs and activities which will be carried on by the President-elect, Jerri Fowler (Longmont), who takes office in April, 1981.

President K. Mason Howard presented the American Medical Association's Speaker's Bureau Award for 1980 (for Outstanding Physician Radio or TV Host) to Mrs. Joan Hamstra, widow of Roger Hamstra, M.D., the host of the television program, "Medicaline." Dr. Hamstra received the first-place "Gold Award" from AMA for his work on the long-popular program co-sponsored by the Colorado and Denver Medical Societies and the University of Colorado School of Medicine. Dr. Hamstra died in a tragic aircraft accident on January 20, 1981. The award plaque was presented to Mrs. Hamstra before the assembled CMS House of Delegates.

**NOTED MEDICAL NEWS COMMENTATOR WARNS IT'S TIME
TO COMPETE!**

The Keynote speaker for the 1981 Interim Session was Dr. Harold Schwartz, (PhD., Columbia University), a widely-known medical journalist-commentator. Dr. Schwartz is the editor of the publication, "Private Practice," the author of the book, "THE CASE FOR AMERICAN MEDICINE," and a former member of the Editorial Board of the New York Times for 30 years. He is a frequent contributor to major newspaper and news publications in the U. S. concerning medical issues. Following are highlights of his address to the Colorado Medical Society House members:

Dr. Harold Schwartz told the physicians "the chickens have come home to roost." Medicaid and Medicare are costing "an arm and a leg...plus some other vital organs." He said that Medicare, paid for by the federal government, is costing more than the public wants to pay. There are many alternatives to these health programs being discussed by the Reagan Administration, and not all members of the administration are anti-Medicaid or Medicare.

Schwartz held out some bleak prospects for physicians in the next few years: the number of doctors have increased since 1965 by 100%. Things are changing, and the doctors can't expect to maintain their present income. He said that the AMA is already conducting courses to teach doctors to negotiate. In 1965, when Medicaid and Medicare were introduced, Schwartz said, there was a pattern set. That pattern is now falling apart.

Dr. Schwartz went on to say the Reagan Administration is presently talking about creating a system of private HMOs, to give cheaper care, which will cost less through an HMO, withdraw the fee-for-service programs and create a total HMO system. He added that the HMO concept has been very successful, but that there are only 9-million Americans in HMOs (4%) presently. He said Massachusetts has already applied for participation in a state HMO program.

Schwartz added that there is grave danger of the Social Security System being bankrupt by next year....that some have even suggested borrowing from the Medicare program to fund Social Security. He pointed out that business, as a whole, no longer backs the doctor, as noted by the number of corporations and industries now instituting their own employee health programs and stating: "This is what we'll pay, Doctor; take it or leave it."

So what's wrong with medicine? Schwartz says "There ain't no competition. The government medical bill will soon be out of sight, so the answer is to introduce competition. As an example, an employer would offer an HMO plan to the employee for X dollars. Another HMO group will come in and offer you a plan for less money."

Dr. Schwartz closed by saying that the AMA was correct in 1960: involving government would (and did) cause limitations in medical practice. The AMA is forced to do something!

K. MASON HOWARD, President of CMS, was directed by Speaker of the House, RICHARD BEDELL, MD, to present to a closed session of the House his report on malpractice insurance negotiations and the cost-effective study which was contracted by CMS with the V. O. Shinnerer & Company.

(Continued on Next Page)

DR. HOWARD reviewed the three weeks negotiations between The Hartford Company, the broker for CMS and the CMS Executive Committee, outlining the alternatives that CMS has suggested to The Hartford, which were: 1. Continue Hartford program; 2. Continue with Hartford with a deductible feature through a Colorado trust; 3. Contract with another major insurance company, and; 4. Form a Colorado captive insurance company.

Negotiations with The Hartford are to continue, and DR. HOWARD stated that the full membership of CMS would be kept informed of the progress of these negotiations.

The House of Delegates APPROVED the further study of such a captive insurance company being formed by the Colorado Medical Society.

LEGISLATION

...Adopted policy positions on national health issues regarding (1) reduction in federal regulations impacting health care delivery system, (2) states' responsibility, (3) "block" grants to states for health programs, (4) elimination of federal peer review systems including PSRO, (5) abolition of Federal Health Planning Activities, (6) Elimination of preferential treatment of Health Maintenance Organizations concerning federal loan subsidies, (7) local Health Services Corps Program.

...Referred to the Board of Directors for further consideration a request to study the implications of repealing the Kadlecik Amendment.

...Supported retaining the National Maximum Speed Limit, at least on the rural primary and secondary highways.

...Supported legislation concerning a pilot program for the medically indigent, otherwise known as the "State Health Plan."

INTERPROFESSIONAL RELATIONS

...Expressed concern about the value of the Quality Assurance Standards of JCAH and suggested the program be reevaluated and that hospital surveys be done jointly by physicians practicing in Colorado.

MEDICAL SERVICE

...Granted the Committee on Rural Health and Medical Manpower an extension until the 1981 Annual Session to make recommendations on future of committee.

...Encouraged physician involvement in prison health care.

...Supported continuation of CMS jail health project beyond its scheduled conclusion in May, 1981.

...Urged CMS to take an active role in state planning and implementation processes of emergency medical services program as they evolve.

...Asked for a progress report at 1981 Annual Session on chiropractic training and practice.

...Asked the Council on Medical Service to review reports on alternative health care ideologies and recommend methods to disseminate this information to CMS members.

PUBLIC HEALTH

...Approved CMS, in conjunction with component societies and CMS Committee on Medical Aspects of Sports, developing a list of physicians interested in sports medicine and willing to provide consultation and services for school and other non-profit community athletic events.

...Support continuation of routine screening of newborn infants.

PROFESSIONAL EDUCATION

...Requested a report at the Annual Session on the Future of Colorado Medical Society Educational Programs.

SOCIO-ECONOMICS

...Approved a three-point program to be pursued by CMS in the area of Medicaid reimbursement, as proposed by the Special Committee for Negotiations and approved by the Board of Directors.

ORGANIZATIONAL

...Approved implementation of President Howard's proposal to establish a closer relationship between CMS and the Colorado Foundation for Medical Care, e.g., by (1) placing the Foundation in a reporting position similar to that of the CMS Councils, (2) recreate Reference Committee on Foundation Affairs; (3) provide the Board of Directors of CMS a monthly report on Foundation activities; (4) joint meeting of the Board of Directors.

...Approved a revised organizational structure, as proposed by Dr. Howard, that would streamline the reporting system between the Board, Council and House of Delegates, and referred the concepts to the Organizational Study Committee to be embodied in the future revision of the Constitutions, Bylaws and Standing Rules.

...Adopted the following Standing Rules, as amended: Chapter 1. Officers and Other Elected Persons, Section 1. Honorarium for President and President-Elect; Chapter 2. Meetings, Agendas, and Attendance of Members of Boards, Councils, Committees and Subcommittees, Section 1. Meetings, Section 2. Agenda, Section 3. Attendance; Chapter 3. Indemnification of Officers, Directors, Members of Councils, Committees and Staff; Chapter 4. House of Delegates, Section 1. Resolutions and Reports to the House, Section 2. Confidential Reports, Section 3. Fiscal Impact of Reports and

Resolutions. Section 4. Reference Committees.

...A resolution requesting a change in the dues payable date was defeated as the concept was covered in another resolution which was adopted.

...A resolution requesting provision for "Active Members On Leave" classification was defeated; the problem of extenuating circumstances in reference to dues covered elsewhere in the 1980 Bylaws.

...Amended the Bylaws clarifying which physicians are eligible for Active Junior membership classification and the dues structure.

...Amended the Bylaws to permit all past presidents of the CMS to be ex officio, non-voting members of the House, and present members of the Board of Directors to be ex officio members of the House with the right of discussion, to introduce new business or resolutions, make or second motions, but without right to vote.

...Amended the Bylaws charging the Nominating Committee with the responsibility of nominating a qualified person for each elective office, including Judicial Councilors, but not Historian and members of Councils, who are nominated by the Board of Directors.

...Amended the Bylaws changing the due date for reports and resolutions to the House of Delegates to 40 days prior to the meeting of the House.

...Amended the Bylaws to provide for filling vacancies in the offices of President and President-Elect.

...Amended the Bylaws so that annual dues for each calendar year become due and payable October 1, with the suspension date January 15; if suspension for non-payment of annual dues is not received by June 30 membership is terminated. Members elected after July 1 but prior to December 1 shall be assessed for one-half year.

...Amended the Bylaws regarding the composition of the Grievance Committee so that whenever possible at least two of them shall be from each Director District of the Society.

OTHER ACTIONS

...Elected the following individuals to the 1981 CMS Nominating Committee:

District I - Robert Hartley, M.D.
 District II - Lynwood Hopple, M.D. -
 Adams County-Aurora Medical Society
 Mark Rubwright, M.D. - Boulder
 County Medical Society
 Stuart Silverberg, M.D. - Clear
 Creek Valley Medical Society
 J. Phillip Nelson, M.D. - Denver
 Medical Society
 District III - Kenneth Lovell, M.D.
 District IV - Wesley Boucher, M.D.
 District V - Patrick Moran, M.D.

Delegate Attendance 1981 Interim Session

DISTRICT I - 18 DELEGATES

LARIMER - 8 Delegates

(A) Chase, Jerry A. (1-2)
 (D) Bruns, Thomas H.C. (1)
 (D) Merkel, Lawrence A. (1-2)
 *(A) Mott, John M. (1-2)
 (D) Cronin, John C. (1-2)
 *(A) Johnson, Robert V. (1-2)
 *(A) Rollins, Donald R. (1-2)
 (A) Allan, David K. (1)

MORGAN - 1 Delegate

(D) Thompson, Patrick L. (1-2)

NORTHEAST COLORADO - 2 Delegates

None Present

WASHINGTON-YUMA - 1 Delegate

None Present

WELD - 6 Delegates

(D) Bagley, David L. (1-2)
 (D) Baldwin, Thomas E. (1-2)
 (D) Foulk, Arnold R. (2)
 (D) Cash, Robert L. (1-2)
 (D) Hartley, Robert D. (1-2)
 (D) Kosloff, Stephen R. (1-2)

DISTRICT II - 120 Delegates

ADAMS COUNTY-AURORA - 8 Delegates

(D) Delaney, James J. (1-2)
 (A) Hopple, Lynwood M. (1-2)
 (D) MacPhae, William M. (1-2)
 (D) Kitlowski, Noel P. (2)
 (A) O'Dell, Robert A. (1-2)
 (D) Ddekirk, Larry (2)
 (D) Martin, William M. (1-2)

ARAPAHOE - 14 Delegates

(D) Knize, David M. (1)
 (A) Ehlers, Gordon M. (2)
 (D) Seegers, Winifred (1-2)
 (D) Thompson, Richard M., Jr. (1-2)
 (D) Blease, Ernest B. (1)
 (D) Freed, John M. (1-2)
 (D) Graisman, Stewart L. (1)
 (A) Robertson, John L. (1-2)
 (D) Milligan, Gatewood C. (1-2)
 (D) Sargent, Frank T. (1-2)
 (D) Spalter, Roger H. (2)

BOULDER - 11 Delegates

(A) Benson, Alan E. (1)
 (D) Edwards, David L. (1-2)
 (D) Kelley, Savarance B. (1-2)
 (D) Smith, Darwin W. (1-2)
 (D) Stormo, Alan C. (1-2)
 (D) Avery, John D. (1-2)
 (D) Cletcher, John D. (1-2)
 (D) Rubright, Mark W. (1-2)
 (D) Stein, Donald W. (1-2)
 (D) Wilson, Don E. (1-2)

CLEAR CREEK VALLEY - 20 Delegates

(D) Brundige, Richard (1-2)
 (D) Call, William H. (1-2)
 (D) Cedars, Chaster H. (1-2)
 (D) Ford, John J., III (1-2)
 (D) Henderson, Kenneth R. (1-2)
 (D) Markel, William R. (1-2)
 (D) Oppenheim, Walter H. (1-2)
 (D) Silverberg, Stuart O. (2)
 (A) Collier, Robert (1-2)
 (D) Stevens, Wayne E. (1-2)
 (D) Weston, Eugene (1-2)
 (D) Campbell, Bernard E. (1-2)
 (A) Greenberg, David C. (1)
 (D) Goldberg, Thomas H. (1-2)
 (A) Rosenberg, Alan (2)
 (A) Molan, Leo (1)
 (D) Ritzman, Vernon D. (1-2)
 (D) Sadler, Dean L. (1-2)
 (D) Tegtmeler, Ronald (1-2)
 (D) Whitcel, John (1-2)
 (D) Yakaly, M. Robert (1-2)

DENVER - 64 Delegates

(A) Newman, Thomas (2)
 (D) Blanchat, David (2)
 (D) Bosworth, Robert G., Jr. (1-2)
 (A) Park, Richard K. (2)
 (D) Butterfield, Donald G. (1-2)
 (D) Craigmillie, Thomas J. (2)
 (D) Cundy, Richard L. (2)
 (A) Jackson, Charles T. (1-2)
 (A) Gelfand, Daniel E. (1-2)
 (D) Delauro, John E. (1-2)
 (D) Elliott, Robert V. (1-2)
 (D) Engal, Stephen (1)
 (D) Flax, Leo J. (1-2)
 (D) Gallagher, John Q. (1-2)
 (D) Galloway, W. Ben (1-2)
 (A) James, Albert E. (2)
 (D) Hamilton, Paul K., Jr. (1)
 (A) Kall, Thomas J. (1-2)
 (D) Inkret, William, Jr. (1-2)
 (D) Leidholt, John D. (2)
 (D) Livingston, Wallace M. (1-2)
 *(A) Kurowski, J. L. (2)
 (A) Lightburn, John L. (1-2)
 (D) Odom, Thomas J. (1-2)
 (A) Nelson, J. Phillip (1-2)

(D) Nieland, Leo J. (1)
 (D) Sawyer, Robert B. (1)
 (D) Schammel, Janet E. (1-2)
 (D) Smyth, Charley J. (1-2)
 (D) Alkawa, Jerry K. (1-2)
 (D) Alexander, Martin M. (1-2)
 (D) Boyd, Harry R. (1)
 (D) Bramley, Howard F. (1-2)
 (D) Bravo, Jaime F. (1-2)
 (A) Blaney, Loran F. (1-2)
 (D) Campbell, William A., III (1)
 (D) Chambers, Karl T. (1-2)
 (D) Cleare, Roy L. (1-2)
 (D) Cook, William R. (1-2)
 (D) Hoch, Peter C. (1-2)
 (D) Humphries, Jesse H. (1-2)
 (D) Jennings, R. Lee (1)
 (D) Klapper, Jack A. (1-2)
 (D) Kovarik, Joseph L. (1-2)
 (D) Miller, Edward S. (1-2)
 (D) Nelson, Nancy E. (1-2)
 (A) Howell, Ira (1)
 (D) Parsons, Donald W. (1-2)
 (D) Pack, Mordant E. (2)
 (D) Philpott, Osgood S., Jr. (1-2)
 (A) Major, Francis J. (2)
 (D) Reimers, Wilbur L. (1-2)
 (D) Mowry, Norman C. (1-2)
 (D) Sawyer, Kenneth C., Jr. (1-2)
 (D) Sides, LeRoy J. (1-2)
 (D) Stanfield, Clyde (1-2)
 (D) Sullivan, Robert C. (1-2)
 (A) Riley, John C., III (1-2)
 (D) Toll, Gilas D. (1-2)
 (D) Toll, Henry W., Jr. (1-2)
 (D) Woodard, W. Donald (1-2)

UNIVERSITY OF COLORADO MEDICAL STUDENTS - 3 Delegates

(D) Lovell, Mark A. (1-2)
 (D) Starkebaum, Mark A. (1)
 (D) Kimble, William K. (2)

DISTRICT III - 18 Delegates

EASTERN COLORADO - 1 Delegate

(D) Keefe, Jerome L. (1-2)

EL PASO - 15 Delegates

(D) Crawford, Lewis A. (1)
 (D) Dawson, Dwight C. (1-2)
 (D) Lloyd, William E. (1-2)
 (D) Lovell, Kenneth R. (1-2)
 *(A) Chatfield, John M. (1-2)
 *(A) Thatcher, D. B. (1)
 (D) Pollard, Joseph S., Jr. (1-2)
 (D) Baron, J. Gregory (1-2)
 (D) Cooper, Jack (1)
 (D) Hanson, J. R. (1-2)
 (D) Kandel, George E. (1-2)
 (D) Martz, John A. (1-2)
 (D) Martz, David C. (1-2)
 (D) McMullen, R. Bard (1-2)

INTERMOUNTAIN - 1 Delegate

None Present

LAKE - 1 Delegate

None Present

DISTRICT IV - 18 DELEGATES

CHAFFEE - 1 Delegate

None Present

FREMONT - 2 Delegates

(D) Vincent, Jack (1-2)
 *(D) Greenlee, Lynn F. (2)
 *(A) Hildebrand, Jan S. (1)

HUERFANO - 1 Delegate

None Present

LAS ANIMAS - 1 Delegate

None Present

OTERO - 2 Delegates

(D) Baumgartner, Robert B. (1-2)
 (D) Knaus, Kendal C. (1-2)

PUEBLO - 8 Delegates

(D) Dingler, Robert W. (1-2)
 (A) Reichert, Thomas R. (1-2)
 (D) Dwyer, Rodney C. (1-2)
 (D) Lenz, Theofora R. (1)
 (D) Smith, Harold J. (1-2)
 (D) Boucher, Wesley W. (1-2)
 (A) Courtwright, Claiborne L. (2)
 (D) Phelps, Harvey W. (1-2)

SAN LUIS VALLEY - 2 Delegates

(D) Kenoyer, Ray M. (1)

SOUTHEASTERN COLORADO - 1 Delegate

(D) Krausnick, Keith F. (1-2)

(Continued on Next Page)

expand this type of offering to Denver stations during 1981. This, however, is extremely difficult because of the necessary involvement of you, the physician, in each program. I understand that you simply don't have the time to devote, in the very regimented schedule that television demands, so there is no overnight solution to our problems in this area.

I have asked each Colorado Medical Society component President to name one person, be they staff or officer of that component, as the public information spokesman for that component. It is vital that the Communications Division has one person through which all requests, questions and answers about public information and communication be funneled. It is also vital that I have one person to provide all of the resources and plans of this division for the current and future public information programs. This request comes in the form of a letter, which should have reached you by the time you read this, so please respond as soon as possible.

"HEALTH POWER" is alive and well, and blossoming with spring. It creates a very desirable image, and carries important health information to the public from your offices. Our thanks to all the people who have helped and contributed:

Colorado Medical Society Auxiliary members
CMS Public Information Committee
CMS Officers and Directors
University of Colorado Health Sciences Center,
Department of Biomedical Communications.
Computer Image Corporation of Denver.
Paul Conly, composer, arranger, special musical
effects, Denver.
Gerald T. Quinn, independent television
field producer & technician, Denver.
George T. Vardaman, and his company,
Burroughs - Wellcome.
Dillon Stores of Colorado.
Associated Grocers of Colorado.

And the many staff people of CMS.

Bill Pierson, Executive Director
Division of Communications
Colorado Medical Society

Highlights of Board of Directors' Meeting Colorado Medical Society March 13, 1981 Sheraton, DTC, Denver

K. Mason Howard, M.D., President, CMS, reported to the Board of Directors that three weeks of negotiations had been completed between The Hartford Insurance, Warren & Sommer, Inc., (broker) and the CMS Executive Committee, concerning a renewal of the malpractice insurance contract. Dr. Howard said that the Executive Committee had presented The Hartford with three

alternatives, any one of which would be beneficial to the CMS membership by reducing the costs of the insurance, by placing CMS in an administrative and fiscal control position with greater participation by CMS in the reserve dollar pool. Dr. Howard added that The Board of Directors and Executive Committee had earlier approved study of a captive insurance program concept, and that this was a possible alternative, as well.

Dr. Howard pointed out that the alternatives offered The Hartford were calculated to return the operation of the malpractice insurance program to the Colorado Medical Society in a period of three to five years. He added that The Hartford was to reply to these discussions by Monday, March 16, 1981, and that the CMS membership would be kept advised of the negotiations results.

MEMBERSHIP CLASSIFICATION CHANGE REQUESTS

Board members were asked to approve the classification of three members representing three component medical societies, and there was discussion about the "carte blanche" acceptance of recommendations made by the component societies for "financial hardship" classifications. It was also noted that the Bylaws state that the component society is to make the necessary recommendation to Colorado Medical Society Board members, with appropriate substantiating information; therefore, there was little necessity for the CMS Board to discuss the matters. It was voted to have the CMS staff distribute guidelines concerning membership reclassification to the component societies, to be certain there is enough supporting information for such reclassification to be acted upon.

DISTRICT REPORTS

DR. ROBERT LINNEMEYER, representing District V, reported that there was considerable concern on the Western Slope about the activities of the chiropractors, both in the area of the high colonic irrigation and in a new tack of using "laser beam treatments for the removal of facial skin wrinkles." DR. LINNEMEYER reported that, despite the thorough investigation and reporting by the Colorado Department of Health, colonic irrigation is still flourishing in Grand Junction, Montrose and Gunnison. Instead of being bitter or accusatory about the Chiropractors, DR. LINNEMEYER said, the public in the area show no signs of bringing any legal action or in finding the chiropractors at fault. DR. LINNEMEYER called for some CMS Board or staff action to educate the public to the matters of alternative health ideologies.

COUNCIL ON SOCIO-ECONOMICS

The Board of Directors approved the request of DR. RAY PAINTER, Chairman, Council on Socio-Economics, to designate Yuma County as a



Hypertension Rounds

Clinical discussions with noted specialists

- ▶ The Elderly Hypertensive
- ▶ The Unresponsive Hypertensive
- ▶ The Complicated Hypertensive
- ▶ The Mild to Moderate Hypertensive

PROGRAM CHAIRMAN

Barry J. Materson, M.D.
University of Miami
School of Medicine
Veterans Administration
Medical Center
Miami, Florida

FACULTY

Ray W. Gifford, Jr., M.D.
Cleveland Clinic Foundation
Cleveland, Ohio

George A. Porter, M.D.
University of Oregon
Health Sciences Center
Portland, Oregon

Philip S. Vigoda, M.D.
University of Colorado
Health Sciences Center
Rose Medical Center
Denver, Colorado

DATE/TIME/CITY

Wednesday, June 3, 1981
1:00 p.m.
Denver, Colorado

CME CREDIT

Meets the criteria for
4 CREDIT HOURS in Category 1
for the Physician's
Recognition Award of the AMA.

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Denver, Colorado

No registration fee. Mail this coupon to register and receive complete attendance information.

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YES, please register me for the Hypertension Rounds in Denver on June 3, co-sponsored by the American Society for Clinical Pharmacology and Therapeutics and the Rose Medical Center, Denver, CO. I understand that attendance is free and will entitle me to 4 hours of Category 1 credit for the Physician's Recognition Award of the AMA.

NAME _____ M.D.
(please print)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Specialty (check one) ☐ General Practice ☐ Family Medicine

☐ Internal Medicine ☐ Cardiology ☐ Osteopathy

☐ Other (specify) _____

Members of the Pueblo County Medical Society recently pointed out an article in a newspaper publication called *Health Care News*, published by the United Nurses, Professionals & Health Care Employees, Local 7, UFCW AFL-CIO. The article was headlined: "Medicaid Fraud Becoming Big Business." The article quoted Mr. John Vayden, Chief Medicaid Fraud Investigator for the Colorado Bureau of Investigation. Mr. Vayden addressed the Committee for Quality Health Care in September, 1980, saying that Medicaid fraud will cost the taxpayers billions of dollars, yet all too often investigation of this crime appears unexciting to the law enforcement agencies because most law enforcement officers are "totally unequipped to deal with sophisticated business men." Mr. Vayden told the committee "of the extent of the abuses," saying "There are inadequate controls upon the [Medicaid] expenditures. No one seems to have anticipated that professionals such as physicians, dentists, pharmacists, nursing home and hospital administrators would intentionally set out to defraud the program on a massive scale, yet that is precisely what has happened."

Colorado Medical Society, when referred to the publication, wanted Mr. Vayden to be somewhat more precise. *Colorado Medicine* Editor, Bill Pierson, talked with Mr. Vayden, his Supervisor, Mr. Howard Gillespie who, in turn, talked with the CBI Director, Mr. Ray Enright. Through these three, *Colorado Medicine* learned that Mr. Vayden's address to the Com-



mittee was based on Medicaid fraud statistics from 29 states, and that he was not singling out Colorado.

As Rodney Dwyer, MD, President of Pueblo County Medical Society, pointed out, it seems only fair that the Colorado side of the story be presented, and the CBI Agents were fully cooperative in providing the following figures:

The Medicaid fraud unit in Colorado was activated in July, 1978 (2 years and 8 months' data collected, as of March 17, 1981). During this time, there have been 50 complaints in the state involving physicians and

Medicaid fraud on a "massive scale" doesn't seem to apply to Colorado physicians.

suspected Medicaid fraud. Of these 50 complaints, which were received from the general public, local and state agencies, etc., 4 civil actions resulted in which money was recovered, 6 complaints were referred to agencies other than the CBI, and 1 case has resulted in a criminal action, which is still pending.

In any case where money is recovered and punitive damages are collected, the monies recovered are refunded to the State Social Services Department and the Federal Medicaid Agency according to the percentage each pays into Medicaid reimbursement. Punitive damages are paid into the General Fund of the State of Colorado.

It would seem that Colorado has quite a good record, based on comparison with the other 28 states lumped into the "massive scale" description. However, one such claim

of fraudulent activity on the part of any person in Colorado is bad. There is a positive side to this issue: It should further put Colorado physicians on alert to be certain their Medicaid billing is proper and correct, and that if there seems to be any impropriety the physician should initiate the query into the matter, rather than to wait for this to become a matter of police investigation.

There is another important point to consider: Mr. Vayden stated that the police agencies were ill-equipped to do this type of investigative work in the "sophisticated business men" atmosphere. Colorado Medical Society members *can* and should be of help in this area! There should be a working relationship developed between these investigators and our profession. There should be no reason for such misunderstandings of professions or statistics to occur. CMS will be actively pursuing a firm communication link between our offices and these specialists which, I think, is the "proactive" approach this society should maintain. If there is a lack of understanding at any level concerning our profession, it is vital to our success that such a weakness is repaired, that communication is effective. We can once again demonstrate a genuine effort to reduce the costs of medical and health care; we can truly aid and abet cost-efficiency by shortening the communication link with such administrative and investigative agencies.

Let me remind you that the Colorado Medical Society is structured in a manner that such allegations, suspicions or questions can . . . and should . . . be handled within our own professional group. The Grievance Committee of CMS (page 23, lines 24-34,

(Continued on next page)

auxiliary report

This time a year ago I urged Auxiliary members throughout the state to "Bloom where you are planted, whether you are a *prairie primrose* or an *urban orchid*, give it all you've got."

Somehow, this prairie flower was planted as Colorado Medical Societies Auxiliary President. I don't know about the blooming, but I do know I've grown. The sunshine and warmth given me by CMS members and staff have been most helpful. Even the fertilizer, I didn't mind.

As CMSA President it has been my privilege and pleasure to serve as a member of the physicians Health and Rehabilitation Committee, Annual Planning Committee, the Scientific and Educational Planning Committee and the Planning Committee for Women's Health Concerns Conference. I have participated in the Component Society Officers and Staff meetings, CMS Board meetings, President's Planning Session and the Public Information Committee. I appreciated the opportunity to address the members of the House of Delegates.

Last summer the Auxiliary conducted a survey on the Physician's Family and passed a jointly sponsored workshop for the physicians and spouses on the results. Recognizing the importance and instability of the family unit, it is the intention of the Auxiliary to continue its focus on the physician family.

For greater efficiency, better communication and a closer feeling of togetherness, the Auxiliary state was divided into five districts this year. A team of 3 Auxiliary members traveled 900 miles in October, visiting each district. The Colorado Medical Society representative in each district addressed the Auxilians, explaining the role of the AMA and CMS in medi-

cine today.

The CMSA holds three board meetings and 2 general membership meetings a year, with the annual meeting in April.

As CMSA President, I have met several times with many committees, including the Metro Council of Presidents, and helped in the planning of "MONEY, MONEY, MONEY."

As of March 1, 1981, I have driven 8,850 miles, throughout the state, and have attended 2 AMAA meetings in Chicago.

Health Power has bloomed in many radiant colors among the nineteen county Auxiliaries: from the vivid red of blood donor programs and CPR training, to the orange of internal healing, the yellow warmth of friendship, to nature's environmental green, to the primary blue of hospital tours for children. The future growth of the CMSA and Health Power is assured by the energy and tender, loving care given by each member. Then, there is the virtual kaleidoscope of colors provided by the metro-area Auxilians to the role of health education. Through their combined efforts, the Hall of Life has accomplished great strides in providing a permanent place in the lives of Coloradans for continuing public health education.

Through the coming year your CMSA will be guided by the able and creative hands of a new slate of officers. As we embark on this new year for CMSA, many new program thrusts will be initiated, while carrying on the good works you have accomplished during the past year. You'll see a re-emergence of *Health Power, A Family*



Kathy Thompson,
CMS Auxiliary President

Affair, you'll see some exciting programs introduced to make the CMSA still more self-sufficient.

Of course, I will still be active in many of the CMSA activities, but could never hope to be as active as during this past year. The year has passed in a sometimes-treadmill, other times frenetic manner, but I'll never lose sight of all of the help, the wonderful associations and the tremendous strides that we, as a group, have made for the Auxiliary's role in Colorado health. To the members of CMSA and CMS, thank you, one and all.

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1980 Bylaws, Colorado Medical Society) "shall continually investigate and supervise the ethical deportment of the membership of the Society, shall make periodic recommendations for improvement of professional conduct, and shall prefer and prosecute before the appropriate judicial bodies, charges against any physician whom the Committee considers guilty of unprofessional conduct. The Grievance Committee shall investigate and review questions of misconduct and the quality of care given by physicians, such investigations including the physicians' professional qualifications, clinical competence, mental or emotional stability, physical condition, or any other matter affecting the quality of care provided by that physician."

The CMS grievance committee is the oldest medical society grievance committee in the United States, even preceding that of the American Medical Association. This fact, alone, bears out my contention that Colorado physicians have always been leaders in their efforts to bring about the very best in medical care and ethical practice. Mr. Vayden's remarks should merely remind us that we, individually and collectively, must continue to make our Society system work.

I am proud of what our membership has done over the years and am confident that Colorado Medical Society will continue to be a leader in quality care and professional conduct.

Once Upon A Time Story

R.G. Bowman, Executive Vice
President, Colorado Medical Society
June, 198- CMS Annual Session
Fairmont Hotel

Dr. Alternate (newly elected): Are all these people from Colorado?

Dr. Delegate: Yes! First time we've had such a turnout. Makes you feel good.

Dr. Alternate: What's so special about this year?

Dr. Oldtimer: Well, it's different than the way it used to be. We used to take days to get through our business. We always seemed to be at odds with the Board and the Staff. As soon as we finished our business the Board took off in another direction. The staff usually put their own twist on what we wanted and it never seemed to be exactly what we wanted. There were always financial constraints and lack of clear goals. Oh, we had the vision, and even the leadership, but no one person could ever get our act together.

Dr. Alternate: That's interesting, because I've only been a CMS member for a few years and this is my first year as a member of the House of Delegates. I've never sensed the problems you've outlined. Is that because our members are Western Slope?

Dr. Delegate: I doubt it. As Dr. Oldtimer said, years ago we had geographical differences, component differences, hospital rivalries and individual priorities. Members were being splintered and divided with every turn. It was even rumored that the only reason physicians belonged to

their medical society was to obtain malpractice insurance.

Dr. Alternate: That's incredible! I expect my medical society to provide me a variety of services, least of which is good, all-round, competitive insurance programs.

Dr. Oldtimer: Well, there were some good services in those days, but most of us didn't know they existed and didn't use them.

Dr. Delegate: That's another big change. My local society offers one a number of valuable benefits and the state society, too. They compliment each other.

Dr. Alternate: I agree. When I first came to town I joined my local, state and national medical societies for a variety of reasons. I needed the practice management courses that I didn't get in medical school OR my residency. I felt good about knowing that my peer group helped set the community standards for my practice and that I had access and input into that process. In turn, my societies do a whale of a job representing me in those issues I care about.

Dr. Delegate: That's the greatest value of membership. Too often, we ignore the many things our organizations do for us because our needs change as we go through our medical careers. Your needs as a new physician are finally being met. Most doctors who are members accept the leadership and policy positions adopted by their medical or specialty societies. However, most of us forget to call on our societies to help us with problems. I remember . . .

Dr. Oldtimer: You know, the CMS and the Auxiliary even helped me and my wife plan for our retirement, list my practice through the placement service and sent me on a second honeymoon cruise. I've certainly

got my dues worth, now *and* over the years.

Dr. Alternate: Our medical society may provide us with some benefits, but I really get turned on with our annual meetings. There are so many things going on! I feel like a kid at my first circus.

Dr. Delegate: You're right! In the old days (with all due respect to you, Dr. Oldtimer) we did one thing at a time. Now, there is something for everyone: the Board, the House, the Reference Committee meetings . . . they're all well thought out. I really get a feel for where we are going.

Dr. Oldtimer: You know . . . I still enjoy the scientific programs, even though I have to pick and choose which to attend. Sometimes it is frustrating, but more worthwhile.

Dr. Delegate: What is amazing to me is that many other health organizations affiliate with us at the same time; sure does improve communications and keeps the profession together.

Dr. Alternate: Hey! I've got to go. I'm seated as a Delegate and I want to be there for the folderol.

Dr. Delegate: You mean the special award?

Dr. Oldtimer: What award?

Dr. Alternate: *Colorado Medicine* was voted as the best state publication by the AMA.

Dr. Delegate: Not that one; the special award for greatest increase in AMA membership.

Dr. Oldtimer: Didn't we get an award for most effective legislative program and PAC funds raised?

Dr. Delegate: That was last year! This year, the biggie is -----!!

Most Surgery Is Appropriate, Colorado Doctors Determine

The legislative session has run approximately half its course, and all bills must have cleared the house in which they were introduced by April 13th. The announced schedule requires that bills be reported out of committee in the second house by April 27th, that they be passed by the second house by May 6th, and that the legislature recess on May 18th and adjourn sine die on June 30th. Some of these dates will, no doubt, have to be extended somewhat, but every attempt will be made by the legislative leadership to meet the published deadlines.

The first two months of the session moved slowly as new legislators were integrated into the process, first-time committee chairmen mastered their roles, and the philosophic beliefs that were to dictate this session's outcome surfaced. Colorado legislature mirrors the federal Congress in its strong feelings against big government and governmental regulations of any sort. Water is a subject of annual interest to our legislature, but this year's drought accentuates that interest. Energy development with its accompanying growth of population and drain on resources is also at the top of the list. Rural health care delivery and attracting of health care personnel are interwoven throughout these discussions.

House Bill 1301, the medically indigent health insurance bill sponsored by Rep. Betty Neale (R), Denver, embodies the concept that CMS, at its annual session in September, placed at the top of your lobbyist's priority list. In a conservative legislature, it is difficult to sell, especially when many of its members think that medical indigency is a problem only encountered by Denver General Hospital. Hospitals throughout the state have their own horror stories to tell, and slowly the educational job is being accomplished. H.B. 1301 includes two

parts: a pilot program for private insurance for the 'working poor' and a pilot catastrophic insurance program. The bill will probably pass or fail, based on the number of state dollars available after the long appropriations bill is passed, probably in late April or early May.

As always in the odd-numbered years or "long sessions" when bills on any subject matter can be introduced, there is a large number of bills pushing for more privileges for allied health personnel. The chiropractors, optometrists, and podiatrists have banded together as "COPs" and, unfortunately, can attract social workers, clinical psychologists, dentists, etc., on isolated issues. It is a difficult group to defeat.

Large numbers of mental health bills have surfaced, due to the crimes committed by mental health patients in the last year. Most of the bills and the requests for funding are based on tighter security, better follow-up, and more hospital and medium level beds. This, of course, has the community mental health centers in a frenzy for fear that they will lose the money that they have come to expect during the years of more lenient mental health care. The Colorado Psychiatric Association has its own lobbyist, Frank Hays, Jr., who is doing a superb job.

A number of physicians and auxiliaries have visited the legislature this year, and it is fun to see how interested in the process they become. There is still plenty of time, and there are lots of fireworks left. Do plan to spend a day at the capitol!

NOTE: If you would like to arrange a "day at the capitol for yourself and members of your specialty or component society, please call the Government Affairs Division, Colorado Medical Society, at 861-1221, Ext. 266, and we'll arrange the scheduling.

CHICAGO—Is unnecessary surgery being performed frequently in the United States?

Critics of American medicine contend that many operations actually weren't needed. Medical leaders across the country say otherwise. There have been few measurements.

The Journal of the American Medical Association of Feb. 13 offers a report showing clearly that there is little unnecessary surgery in Colorado. There is no effort to extrapolate this to a national figure, but other states may have similar experience.

The Colorado Foundation for Medical Care Professional Standards Review Organization performed a six-month study to determine if each of 13 commonly performed surgeries were being done in accordance with appropriate indications. Data were collected by nurse reviewers on 4,850 patients in Colorado hospitals.

The findings: 97 percent of the cases either met indications for these procedures or were justified by physician review.

"The conclusion from the study was that Colorado physicians are performing these procedures appropriately," says Robert Elliott, M.D., of the Colorado Foundation for Medical Care, Denver.

Of 201 appendectomies performed, 100 percent met one or more of the indications for the operation. Of the 1,768 cases of cataract removal, 99.3 percent were properly ordered. Some 97.4 percent of the gallbladder removals met at least one of the indications for the procedure.

One of the more controversial operations is hysterectomy, removal of the uterus. Of these cases studied, 93.8 percent were considered justified.

The major area with room for improvement was removal of tonsils and adenoids. Almost 10 percent did not meet requirements for surgery.

Says Dr. Elliott, "We found only a 3 percent incidence of procedures that failed to meet indications or physician review for appropriateness, which is substantially less than the 17.6 percent unnecessary surgery rate

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District Attorney Discusses Drugs with Medical Society

Spurred by increased reports of drug problems among nurses at Denver area hospitals, the Alcohol and Drug Abuse Committee of the Denver Medical Society recently invited Dale R. Tooley, Denver District Attorney, to confer with the committee. His comments and suggestions were enlightening.

Tooley felt physicians, generally, were very cooperative in the recent incidents. He also expressed the feeling that physicians can exert a strong influence to correct this type of problem. Tooley indicated that hospital administrators and legal counselors were not current about the 1979 reporting law which requires incident reporting by institutions. The most difficult hospital drug abuse problems are substituting of ordered drugs and drug switching, he said.

Tooley volunteered that lawyers

really have a worse problem in reporting errant attorneys who steal clients' money, but he stated that the Colorado Bar Association has the only functioning program among professional associations for impaired members. (At the March 14-15 Interim Session of the Colorado Medical Society House of Delegates, the CMS program developed by the Committee on Physician Health and Rehabilitation were reported to be operational.) (See *Impaired Physician Program Operational* in this issue of *Colorado Medicine*.)

Neither the Colorado Hospital Association nor the Colorado Nurses Association has developed employee assistance programs, Tooley said, but CHA is now developing standard procedures for drug-related problems which should be available soon.

According to Tooley, suspected crimes should be reported to appropriate licensing boards and to law enforcement agencies. Most reporting has been done by patients, the nursing board, hospitals and employees (both anonymous and identified). The Colorado Department of Health has reported some suspected crimes as part of its role under the controlled substance statutes. He strongly stated his office's preference for getting people into treatment . . . not into jail.

Tooley urged physicians to become more aware of what could happen in their offices and to inform themselves of the methods by which drugs can be stolen. He doesn't want to turn physicians into policemen, but wants them to increase their awareness and asks them to stay alert to possible problems.

EAR, NOSE & THROAT SYMPOSIUM

For The Family Physician

July 31, August 1 & 2, 1981

at The Lodge at Vail

SPONSOR: The Associates of Otolaryngology, Denver, Colorado.

GUEST FACULTY: 20 distinguished otolaryngologists from private practice and universities.

ACCREDITATION: Approved for 20 hours of credit by The American Academy of Family Practice, The American Osteopathic Association, and The Colorado Medical Association.

COURSE DESCRIPTION: The most up to date material will be presented in a manner that will have relevance to the family doctor. Lectures, panel discussions, and practical workshops on all phases of ear, nose, and throat diseases will be provided by a distinguished guest faculty. Seven hours of didactic material will be provided each day. Updates on treatments and a "How I Do It" format will be used. An outline of all material will be provided in a very complete syllabus.

TUITION: \$250.00 per participant.

FOR PROGRAM INFORMATION: E.N.T. SYMPOSIUM, 950 E. Harvard, Suite 500, Denver, Colorado 80210, or call Lisa Lee, Program Secretary, (303) 744-1961.

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cited by the House of Representatives Subcommittee on Oversight and Investigations of the Interstate and Foreign Commerce Committee in 1976."

The American Medical Association has contended that statistics advanced to support the premise that many operations are unnecessary are invalid, and that relatively little surgery is being done that is not of direct benefit to the patient.

Council on Professional Education

February 4, 1981

The meeting began with Chairman Patrick Moran introducing Ronald D. Franks, M.D., as the Council's new member representing the School of Medicine, and Ms. Kim Pierpoint, the Colorado Consortium for Continuing Medical Education's new Program Assistant.

N. Kenneth Furlong, M.D., Chairman of the Council's Committee on the Future of CME, reported that the committee had met to determine its approach to producing the report on the CMS's future role in CME. That report was requested by the House of Delegates for the 1981 Annual Session. A key question for the committee is whether the Medical Society should be a provider or a broker of CME. The committee, comprised of Dr. Furlong, Dr. Moran and William Shiovitz, M.D., will meet again shortly.

David Kelble, M.D., Chairman of the 1981 Annual Session Educational Program Planning Committee, reported that the first meeting of the Committee would be held on February 17. At that time a schedule, topics and possible speakers would be discussed.

Harry Locke, M.D., Chairman of the Ad Hoc Committee on Medical School Relations, reported that the committee had yet to meet. He suggested that the committee examine which of the University's educational problems CMS can help to solve. Other committee members are Dr. Franks, Dr. Furlong and Franklin Yoder, M.D.

Kevin Bunnell reviewed the status of the accreditation program:

- The proposed policies and procedures for the accreditation program

has been revised, having passed once through the Accreditation Committee, this Council and CMS legal counsel. The revised version will once again go to the Accreditation Committee and the Council, then ultimately to the Board of Directors for approval.

- Staff is contacting twelve hospitals in the state that have the potential to be accredited for CME. As a result, many are in varying stages of formulating accreditation programs.

- The San Luis Valley hospitals are considering establishing a consortium, with help from the San Luis Valley AHEC, to offer accredited CME throughout the Valley.

Carol Tempest, CMS Lobbyist and Director of the Division of Governmental Affairs, discussed several bills coming before the legislature that may be of interest to the Council.

The next meeting of the Council was set for May 6th.

Colorado Consortium for Continuing Medical Education

February 5, 1981

The Board of Managers of the CCCME discussed the prospect of expanding the Consortium's membership to possibly include the Colorado Hospital Association, Colorado Department of Health and/or several other educationally-active organizations in Colorado. Staff was asked to make informal inquiries and report at the next meeting regarding interest of those organizations.

The Board reaffirmed its interest and support in the on-going programs of the Consortium, such as 1) its proposed joint effort with the Denver Medical Society and the Health Department to educate physicians in

how to identify patients in early stages of alcohol or drug abuse, and 2) the five CME programs the Consortium and Colorado Hospital Association are sponsoring April-August via the Tele-Net system.

The Board approved the 1980 end-of-year report and proposed 1981 budget.

The next meeting was set for March 25th.

Computers and Telecommunications In Medicine—One-Day Road Show Available

Colorado hospitals may now take advantage of a one-day road show on Computers and Telecommunications in Medicine sponsored by the Colorado Consortium for Continuing Medical Education and the Denver Medical Society. Martha Burroughs, Reference Librarian for the DMS, will conduct on-site, on-line MEDLINE searches for hospital medical staffs, and Kevin Bunnell will give a one-hour overview of present and future uses of computers and telecommunications in medical settings.

This is an excellent opportunity for physicians to learn more about the new technology which will profoundly influence office and hospital practice in the years immediately ahead.

The road show has met with enthusiastic audiences in Grand Junction, La Junta, Montrose and Glenwood Springs. Hospitals sponsoring the one-hour talk have awarded Category 1 credit for the presentation.

Physicians interested in this program should ask their hospital Director of Medical Education to contact Kevin Bunnell, Ed.D., Executive Director, Colorado Consortium for Continuing Medical Education, 1601 E. 19th Avenue, Denver 80218, 861-1221 (outside the Denver metro area dial 1-800-332-4150).

BME Changes Term Of Medical Licensure

Beginning in January, 1981, physicians will be renewing their licenses for a two-year rather than a one-year period. Also, the Board of Medical Examiners has been assigned the month of May as its permanent reporting

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month beginning in 1983. This reflects the need of the Department of Regulatory Agencies (DORA) to stagger reporting periods for all professional boards across the calendar year.

These changes have resulted in some confusion about reporting CME requirements. According to the BME, physicians will still be required to report 20 hours of Category 1 CME credit per calendar year. This means that in May, 1983, physicians must report 20 hours each for calendar years 1981 and 1982—hours are not transferable from one year to another.

There will always be a five-month lag between the end of the two-year CME reporting period and the beginning of the two-year license renewal period.

For further clarification, call or write Lorita Arduser, Secretary, Board of Medical Examiners, State Services Building, 1525 Sherman Street, Denver, CO 80203, (303) 839-2468.

CME Credit by Tele-Net

Colorado physicians will soon be able to meet some of their continuing medical education needs through the use of Tele-Net, the long-distance communication system developed by Elmer Koneman, M.D., and the Colorado Association for Continuing Medical Laboratory Education (CAC-MLE). Through Tele-Net, physicians will be able to participate directly in CME programs being held at designated Tele-Net locations throughout the state via a two-way telephone system featuring conference-style communication. One hour of AMA Category 1 credit will be awarded for each hour of participation.

Following a successful demonstration of an experimental Tele-Net program on atherosclerosis at the Colorado Medical Society Annual Session in September, 1980, a special Task Force on Telecommunications was formed by the Colorado Consortium for Continuing Medical Education (CCCME). The task force, with representatives from the University of Colorado Health Sciences Center, Colorado Medical Society, the Veterans Administration and the Colorado Hospital Association, is pursuing development of CME for physi-

cians via Tele-Net until permanent support can be found.

Locations from which Tele-Net programs will originate are: the University of Colorado School of Medicine, Denver; Penrose Hospital, Colorado Springs; Montrose Memorial Hospital, Montrose; and Presbyterian Medical Center, Denver. The series of five monthly Tele-Net programs is scheduled for the third Friday of each month beginning April 17, 1981. Topics include: Complications in the Third Trimester, Three Cases of Heparin/Coumadin Monitoring, Tumor Board Conference (Montrose), Clinical Pathology Conference (Penrose), and Emergency Medical Care - Trauma.

Hospitals throughout Colorado are invited to become Tele-Net receivers according to the following fee schedule which includes all five programs: Under 50 beds—\$150; 50-99 beds—\$200; 100 beds and over—\$250.

For further information, write or call Kevin Bunnell, Executive Director, CCCME, 1601 E. 19th Ave., Denver, CO 80218, (303) 861-1221 (outside the Denver metro area dial 1-800-332-4150 toll-free).

1981 Annual Session Educational Program Planning Is Underway

The 1981 Annual Session Education Program Planning Committee has chosen a timely theme for this year's Annual Session in September. David Kelble, M.D., Committee Chairman, announced that this year the educational program would focus on "The Environment," exploring national, regional and local views on three or four topics of immediate interest to Colorado, such as air, water or radiation pollution.

Committee members are: Theodore Dickinson, M.D.; Mrs. Jerri Fowler; Jack Locke, M.D.; Roger Mitchell, M.D.; Patrick Moran, M.D.; John Mueller, M.D.; Robert Schrier, M.D.; Mrs. Kathy Thompson; and Thomas Younge, M.D.

The Committee suggested asking a nationally-known figure to speak at the opening session of the House of Delegates to set the theme of the meeting. CMS staff is pursuing several suggestions.

The Colorado Consortium for Continuing Medical Education and a special Telecommunications Task Force sponsor **TELE-NET**.

TELE-NET offers:

- Direct, two-way participation in CME programs via a long-distance, conference-style communications system.
- 1 hour of AMA Category 1 credit for each **TELE-NET** presentation attended between April 1981 and August 1981.
- Convenient, relevant CME at low cost.

Your hospital may already be a **TELE-NET** receiver, or may become a receiver at very low cost.

Ask your Director of Medical Education or Administrator to contact the CCCME about this special opportunity. Call or write:

Kevin P. Bunnell, Ed. D., Executive Director
Colorado Consortium for Continuing Medical Education
1601 E. 19th Avenue, Denver, Colorado 80218
(303) 861-1221 (Outside the Denver Metro area dial 1-800-332-4150)

See Adjacent Article for More Information.

Federal Peer Review: Fact of Fiction?

On February 18, 1981, the Health Care Standards Committee of the Colorado Foundation of Medical Care met in Denver to hear an address by Charles C. Edwards, M.D., President of Scripps Clinic and Research Foundation of La Jolla, California. Dr. Edwards provided a meaningful look into the Reagan Administration's health care thinking, and he brings this message with the conviction of one who has served three Presidential administrations in health matters and consultation. Charles Edwards last served as Assistant Secretary for Health (1973-1975). Prior to that he was the Commissioner, Food and Drug Administration (1969-1973), after having worked five years with the American Medical Association in various departments. Dr. Edwards received his B.A. and M.D. at the University of Colorado, his M.S. at the University of Minnesota. He served in the United States Navy during World War Two, and again during the Korean Conflict. His current professional affiliations include: Diplomate, American Board of Surgery; Fellow, American College of Surgeons; Member, American Medical Association; Fellow, American Public Health Association; Association of American Medical Colleges; Fellow, Institute of Medicine of Chicago; New York Clinical Society; Society of Medical Administrators.

Dr. Edwards' speech is printed, in full:

I think there is a mild post-election euphoria sweeping over the health care establishment. If I gauge it correctly, a good many of our colleagues

read into the landslide victory of President Reagan, a new birth of freedom for a health care enterprise that had, over the last two decades or more, become increasingly the pawn—perhaps even a plaything—of political and social activists who seemed to operate on a simple creed: Take control of the system away from those who work in it; turn it over to government; and then use the system to do everything from stopping inflation to guaranteeing free care to everyone.

The election seemed to signal, among many other things, a repudiation of that kind of thinking, the rejection of a philosophy and a strategy that had failed to achieve most, if not all, of its goals. The theory that government can manage the health care system more efficiently and more productively than the system can manage itself was turned aside in the zeal to "get government off our backs," as candidate Reagan so artfully put it. And when the voters overwhelmingly endorsed that slogan and the man who pledged to carry it out, you could almost feel the sigh of relief escaping from the private health sector.

Whether that relief, that euphoria, is a fleeting pleasure remains to be seen. I would like to come back to that unsettling thought a bit later. But for the moment, let's consider what the change in administration appears to augur for the American health enterprise.

In the simplest terms, perhaps, we would seem to be on a course toward increasing competition in the health field. By competition, I mean not merely price competition in the traditional sense of market economics. I mean also competition in the quality and availability of health services, competition among schemes of orga-

nizing and delivering care, and competition between the traditional "cottage industry" approach to the dispensing of care and the marketing strategies of vast corporate enterprises that are now coming to occupy a very rapidly expanding place in the private health system.

I think it is clear that the new administration in Washington sincerely welcomes these kinds of competition, that it will, in fact, encourage them by policies of deregulation, tax incentives, changes in reimbursement policies, and decisions to turn substantial portions of government control back to the states to carry out as they think best. If one can discern a guiding principle in the attitude that the Reagan administration will take toward the health care system, I think it is one of reducing as much as possible the direct involvement of government in deciding how the national health dollar is spent—how, and in what amounts, health resources are developed and distributed; which systems of organizing and delivering health services are to be encouraged, and which discouraged; what standards of practice are to be judged acceptable; and whether or not new forms of health care technology are to be allowed to enter the marketplace.

As I list those examples of areas in which it seems the role of the federal government is to be sharply diminished, I find even myself a bit surprised at the enormous scope of federal domination that has evolved over the past three decades. Yet, every one of those aspects of the way in which the system operates is at this moment under close control by the federal bureaucracy. Federal dollars and decisions about how they are to be spent dominate health research

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and manpower training. Health Planning—ostensibly a function of state and community agencies—conforms to rules and guidelines laid down in Washington. Expansion of pre-paid health care programs, while by no means a federal innovation, is certainly a goal of government health planners toward which vast sums have been allocated, while fee for service and other ways of delivering care had to make their way without the benefit of direct government subsidies. Professional standards review organizations despite their general lack of impact on either the quality or the cost of care, are trying at least to transmit federally mandated standards into the examining and operating rooms of the country. And finally, federal decisions regarding what forms of care and what technologies can be paid for under medicare and medicaid are having a powerful influence on the pace and direction of progress in health care and health services.

It is an impressive, almost mind boggling, apparatus for federal control of the health system, and I do not for a minute mean to suggest that it is going to be dismantled overnight. One of the things that I learned in more than a half decade in Washington is that programs once started are very hard to stop. The President and his advisors are rapidly learning that federal aid to biomedical research, for training, for health planning, for H.M.O., and yes even for P.S.R.O.s each have vocal and sometimes powerful constituencies. Some more than others, of course, but I think those of us working in the health care system and very deeply concerned about its future would do well to accept the handwriting on the wall: federal involvement in the working of the American health enterprise is going to diminish, slowly perhaps, but surely. More and more of the decisions that have come to us from Washington already set in concrete are going to be ours to make—right or wrong, win or lose, succeed or fail. We are going to find ourselves a vastly more competitive world in which the equivalent of a Japanese import can threaten the survival of those who can't compete, when the shock of having to pay our way without benefit of federal aid would be somewhat like the shock of having to pay the

world price for oil—now close to ten times higher than we were used to only a few years ago.

For we need to keep in mind that the carrot by which the government made attractive the stick of control was pure and simply, money—money to build hospitals and medical schools and pay people to work and study in them; money to pay for new equipment and defray the cost of using it to take care of patients. I frankly do not know how many hundreds of billions of federal dollars have been poured into the health

Those of us working in the health care delivery system would do well to accept the handwriting on the wall.

care system over the last quarter of a century, but a figure in the range of half a trillion is I think reasonable. Much of that reflects spending under Medicare and Medicaid especially in the last decade. And there is little reason to think that the cost of these two programs will decline, though even that is possible. But the point is that the enormous sums of money that have flowed through the health care system are really indistinguishable from public subsidies; now along with a reduction in federal control, we must recognize that there will almost certainly be substantial reduction in the subsidies that most of us in the health field have come to take for granted, whether or not we were constitutionally willing to acknowledge them for what they are.

For the fact is, we would have to look pretty far to find a segment of American industry more thoroughly and comprehensively subsidised than the health industry. Its raw materials—people, facilities, and knowledge—have been developed largely at public expense. Its product—health services—is paid for very substantially by tax dollars. Frankly, not even the farmer has access to a more pervasive system of public support. What is coming to an end is an era that began roughly at the close of World War II, an era in which virtually all of us were trained to work in a subsidised industry, because it was the only game in town.

So, to put it a bit bluntly, exit the government dole; enter the free market world of competition. Exit, albeit it gradually, the period of tight government control of the health care system, and with it the built-in assurance that the system would sustain the most inefficient, the least productive, the most marginal kind of purveyor of health services, and enter a world where the inefficient, the unproductive, and the marginal will not survive. And because federal policies and spending have virtually assured an over supply of physicians, the numbers of non-survivors may be many.

Let me back off for a minute.

I do not mean to suggest that without the government, the American health enterprise would have degenerated into mediocrity, or contracted into a small, elite service industry that catered only to the affluent and left those without ample means to fend for themselves. Certainly, without massive federal involvement the system would have evolved differently, but there is no reason to conclude—as I think some do—that without government, the health care system would have abdicated its historical role of service to mankind.

But what I am suggesting is that government has allowed, indeed it has probably caused this massive subsidization of the system to place a low value on efficiency, on getting the maximum return on investment. Despite the conventional rhetoric about government seeking to force the health care system to be more cost conscious, there can be little doubt that government spending and government control has tended to make the health care system more wasteful, more redundant, more cost unconscious, than it would have been otherwise. Manifestly, the last quarter century has witnessed significant advances in the effectiveness and benefits of health care, but it has witnessed that progress at enormous costs, so much so in fact that health spending now accounts for twice as much as the gross national product as it did in 1955.

Obviously, President Reagan's goal of reducing federal involvement in people's lives struck a resonant chord among Americans. And like other voters, we in the health field can find much to favor in the prospect of disentangling government from our

work. But in our enthusiasm for a future relatively freer of government control, I hope we will not forget that a free market can impose controls on the system just as forcibly and probably much more effectively than government can—not the controls of law and regulation which we have learned to live with, if not to enjoy; but the controls of the marketplace. And these, I submit, most of us have precious little experience with.

There are many ways in which one could speculate about what a competitive market for health services will be like, and of course all that any of us can do at this juncture is speculate, but let me pick one key to speculation, one that may open up some thought provoking doors.

The health field is going to change overwhelmingly from a seller's market to a buyer's market.

Right now, in 1981, with limited exceptions, the demand for health services, the way in which that demand is channeled and satisfied, and the price paid for services rendered are determined by the sellers, by us. That picture is changing, but in a period of determined government deregulation and the disentanglement from the workings of the health care system, those who buy health care will have much greater incentives to seek out providers that can offer the greatest economies, the most efficiency and convenience—in short, the best product for the dollar—and I would suggest that best product may not be measured entirely by current standards.

I am not, by the way, talking about individual patients, except in the aggregate. I am talking about those organizations that shop for and buy health care on a massive scale; labor unions; large far flung corporations employing people by the hundreds of thousands, public bodies such as city and county governments. These are the health care purchasers that are going to be in a position to dictate to the health industry, negotiate rates and fees, determine where facilities will be located and what range of services they will provide.

And on the other side of the coin, more and more the segments of the health system that will be able to meet this kind of demand will be large provider conglomerates—chains of proprietary hospitals and specialty clinics, networks of providers operating

in regional marketing systems and capable of shifting resources to meet shifting demands.

The critical factor will be flexibility. The ability of the private sector to respond quickly and efficiently to demand, to competition, to the opportunity afforded by new technologies, new financing arrangements, and new advances in the health sciences. Those organizations and individuals that can exploit the freedom that deregulation and increased flexibility will bring, those organizations will prosper in a free market health care

Labor unions, far-flung corporations, public bodies and county governments are going to be in a position to dictate to the health industry.

delivery system. Those that cannot or will not, have, it seems to me, little prospect for survival in the years ahead.

I suppose in the last analysis what I am talking about is the impact of having management of the health care system shift from government to the private sector. The management of huge amounts of capital, of resources, and of marketing, will increasingly be in our hands, without government either looking over our shoulder or, as has often been the case, making decisions for us.

It will be, to put it mildly, a new experience. And as much as critics of the government's role in health care have argued for deregulation and increased autonomy, not many of us have had a wealth of experience as managers in a highly competitive arena. Apparently, we are going to get our wish. And when we do, we will face the severest test that the American health enterprise has ever confronted.

Until recently, it had seemed to me that the future presented several alternate paths for the health care system: complete nationalization along the lines of the British National Health Service; a public utility model wherein resources stayed chiefly in private hands but were subject to strict rate and fee control; and the laissez-faire approach that involved both private ownership and private—or that is

to say—marketplace control of the system.

In my judgment, what slim prospects there were for option one, nationalization, was finally laid to rest in the tide of political and ideological change that swept Mr. Reagan into the White House.

Option Two, the public utility model, still has some appeal for sure, if relatively little political backing.

The public utility model would keep intact the private health care provider system and still offer a mechanism for controlling rates and fees. While it would not eliminate the need for state and local health planning, it would focus planning efforts where they belong—on questions of effective and appropriate allocation of resources. Further, the basic concept of a privately held, publicly regulated resource has a successful precedent in the state energy agencies and the acceptable work that some have done and are doing in parts of the country. To be sure, the record of these public utilities and the commissions that regulate them is mixed. However, on balance, I think they have performed a needed service with generally favorable results.

A significant disadvantage of this approach is its vulnerability to political pressure. One would be naive, indeed, not to recognize that such pressures have influenced the decisions of our energy commissions or to ignore the fact that they could, and would, do the same thing in the health care setting where the list of special interest groups is even longer.

And I believe that the single most serious flaw in the public utility type regulation would be the lack of flexibility such a system places on the regulatory industry. This is a matter of no small consequence since the very significant strides made in U.S. health care are attributable, in large part, to the nation's ability to develop and implement innovative solutions to perplexing problems.

It is perhaps this dimension of the overall question—the preservation of flexibility and innovation—that commends most highly the third option. The private sector has produced, even with its many deficiencies, the best health care enterprise in the world, and the “hands off” alternative will retain, and possibly even further encourage, the application of private initiative in the resolution of

problems within the system. The decision to deregulate—or even to not pursue added regulation—will avoid the need to create new expensive government bureaucracies. It will acknowledge that efforts to control health care economics as an isolated subset of the total economy are patently unrealistic and destined to continue to fall.

The possible drawbacks of now taking a laissez-faire course with respect to the health care system arise from the fact that the ultimate success of such an approach depends heavily upon one key factor. That is, the ability of the private sector to introduce—or, if you prefer, to expand—market-place pressures in the day to day operation of the system.

I would be among the first to acknowledge that, historically, so-called free market incentives have not been as influential in the health care arena as they have been in other sectors of our economy, but that situation is as I have indicated, changing.

Despite the slackening of federal support, I believe that pre-paid health care, perhaps with some modification of its present forms, will become a major element of the health care system of the nation, as it already is in California. It will do so, not because of government initiatives, but because private enterprise is more and more coming to recognize that pre-paid care offers a logical, effective way to control costs. When you consider that U.S. industries invest tens of billions of dollars a year in health care coverage, there seems little doubt that, simply as a matter of economic necessity, they will turn progressively to pre-paid systems that achieve cost reductions. Pre-paid care will not supplant fee for service forms of practice, but it will increase the competitiveness of the system as a whole. Under pressure from pre-paid programs and other alternative health financing schemes, traditional fee for service providers will be obliged to adopt more competitive pricing strategies and strive for greater market efficiency and greater responsiveness to consumer needs. This has already begun to happen.

Many, of course, will disagree with this view of the problems and prospects confronting the health care system—some because they choose not to accept the necessity for change, other because they are so wedded to

their own narrow views that they cannot see beyond them.

Difficult as the challenges we face may be, I am optimistic about the future. I think those of us in the private sector are in a position to demonstrate that we have the understanding, the imagination, and the ability to meet our responsibility to society and to merit the confidence and the support of those who look to us for care. However, the leadership of the health care system must recognize that in meeting these challenges there will be a number of difficult and traumatic readjustments that will have to be made.

If we fail to meet these challenges the champions of an independent health care system will have been defeated, and the door will be open to those who believe, equally strongly, that the management of the health care system should be a function of government.

Impaired Physician Program Now Operational

The Colorado Medical Society voluntary advocacy program to assist physicians with impairment of any kind is now operational, the Committee on Physician Health and Rehabilitation reports.

The Alcohol and Drug Abuse Division of the Colorado Department of Health, in its publication "Helping People,"¹ estimates that 8.9 percent of the Colorado population aged 12 and older are believed to suffer problems from alcohol use and misuse, and that each alcohol abuser affects the lives of at least four others; statewide, it estimates that 6.8 percent of the 12 and over population are drug abusers, males outnumbering females almost two to one.

The Committee would welcome additional advocates; if you are willing to assist in the program, please contact the Committee by writing in care of the Colorado Medical Society office in Denver.

If you are aware of a physician member you believe needs assistance, contact the Committee by call-

Grievance of the Month

Editor's Note: the "Grievance of the Month" column was just established in the March issue of Colorado Medicine, and will be appearing monthly as an aid to your private practice. Names, of course, are fictitious, but the circumstances are those reported in grievances handled by your CMS Grievance Committee.

Complaint: Mrs. Gruff writes to the Grievance Committee complaining that she was charged excessively by Dr. Cutter for a lumpectomy procedure.

Investigation: Mrs. Gruff had recently purchased a health insurance policy and understood that she had "full" coverage of "usual, reasonable, and customary fees." When the insurance payment was \$50 less than the surgical charge, Mrs. Gruff refused to pay. Dr. Cutter was not about to turn the account over to a collection agency.

Disposition: Mrs. Gruff was informed that the Grievance Committee was not a fee-setting organization and does not mediate fees. She was also informed that insurance payments are usually made from a fee schedule that may not reflect current fees. Dr. Cutter was informed that although his fee did not appear excessively high, the complaint may have been avoided by discussing the fee with the patient and encouraging her to check regarding her actual insurance coverage prior to the procedure.

ing the CMS office (861-1221 for the Denver metro area; WATS line for outstate persons is 1-800-332-4150). You may be assured that the program's approach is that of advocate, not of disciplinarian, and that the privacy and dignity of all referrals will be strictly maintained.

¹ Alcohol and Drug Abuse Division, Colorado Department of Health, "Helping People," "Alcohol and Drug Abuse Programming in Colorado," 2-3-1980.

Radiation and Rocky Flats in Perspective

D.C. Hunt, PhD, T.R. Crites, PhD, MPH, and C.R. Lagerquist, CHP

RADIATION EXPOSURE OF PLANT WORKERS

Employees at a nuclear facility, such as Rocky Flats, are potentially exposed to radiation and radioactive materials. Because of the assumption that any exposure to radiation may be harmful, elaborate measures are taken to keep the radiation exposure to employees "as low as practicable" (ALAP) or "as low as reasonably achievable" (ALARA).

Radioactive materials, such as plutonium and americium can be a hazard to employees in two ways. The first is from the radiations which can travel from the material to the person after being emitted during the process of radioactive decay or spontaneous fission. The process of assessing or measuring the doses received by a person from these radiations is called external dosimetry, since the source of the radiation is external or outside the person's body.

External Exposure

Radiations of concern in the plant external dosimetry program are photons (X and gamma rays), beta particles, and neutrons. The primary radiation from the radioactive decay of plutonium, the alpha particle, is not a hazard for sources external to the body as it is easily shielded by a few centimeters of air or by a person's skin.

The primary protection against these external radiations is shielding. At Rocky Flats, plutonium and americium are processed in gloveboxes which are made of stainless steel, supplemented, where necessary, with lead shielding to attenuate the photon and beta radiation and with thick hydrogenous shields such as lucite or water to slow down and to absorb

neutrons. Thick (30 to 50 m) lead-impregnated rubber gloves, attached to glove ports, serve as shielding for hand-on manipulation of the radioactive material in the gloveboxes. Secondary protection is provided by minimizing personnel exposure time to the radiation or by increasing the distance between the operator and the radioactive material. Remote controls are also used for some processes to lessen worker exposure.

The ALARA operating philosophy is applied at Rocky Flats with an upper limit of less than 5 rem per year for whole body penetrating radiation dose equivalent (A penetrating radiation is one which can penetrate at least to a depth of 1 centimeter in tissue). The 5 rem per year value is the maximum permissible dose equivalent for occupational exposure (prospective annual limit) recommended by the NCRP¹ and adopted by DOE (ERDA Manual Chapter 0524). The permissible level implies that a worker could receive this dose yearly for the rest of his or her occupational life (50 years) and not have an undue risk of impaired health.

The dose equivalent, in units of rem or millirem (mrem), is measured by a dosimetry badge which contains detectors which are sensitive to the various types of radiation. Film, thermoluminescent detectors (TLD), and electronic semiconductor material can be used as the sensitive element in the dosimetry badge. At Rocky Flats, the sensitive element in the badge is a set of lithium fluoride thermoluminescent detectors or crystals. Lithium fluoride, enriched in the lithium-7 isotope, is sensitive to the photon and beta radiation. Enriched in the lithium-6 isotope, the material is also sensitive to neutron radiation. When radiation impinges on these

crystals, part of the energy is transferred to electrons in the crystal which are trapped at energy levels above the ground state of the crystal. The energy remains stored in the crystal until the crystal is heated to a high temperature (about 200°C). The trapped electrons are then released, and the stored energy is given off in the form of light (luminescence) which can be measured with a photomultiplier tube. The measured light output from the crystal is therefore a measure of the radiation to which the crystal and the person wearing the badge have been exposed.

At Rocky Flats all employees wear a dosimetry badge although only about 800 are considered to be radiation workers and would be expected to receive more than background levels of radiation. Of these radiation workers, about 180 are involved with glovebox operations with plutonium. Over the past five years, the average dose equivalent received by this group of 180 workers has been 975 mrem with all persons having less than the 5000 mrem maximum permissible limit. The average is less than 20 percent of this limit. For the other 620 radiation workers, the average has been 267 mrem, or 5½ percent of the permissible limit.

Internal Exposure

The second aspect is radiation exposure which comes from radioactive material inside the body. Plutonium can be deposited in the body by inhalation or through a break in the skin. Deposition by ingestion is not probable since plutonium is poorly absorbed through the GI tract (the transfer fraction is on the order of 1×10^{-4} for ²³⁹Pu and ²⁴⁰Pu and 1×10^{-3} for

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^{238}Pu , ^{241}Pu and ^{241}Am).² Once inside the body, the primary contribution of plutonium to the dose equivalent is from the alpha radiation, which is no longer shielded from the body tissue.

Inhalation of plutonium can occur as a result of chronic exposure to ambient levels of plutonium in the air at concentrations much less than permissible amounts or as a result of an accidental plutonium release into the work area. The permissible limit is set such that a worker breathing air with the limiting plutonium concentration 8 hours a day, 5 days a week for 50 years would not accumulate more than 16 nanocuries of alpha emitting plutonium in his lungs. (The quantity 16 nanocuries is considered to be the maximum permissible lung burden for alpha emitting plutonium and is the amount which would deposit the annual dose equivalent limit of 15 rem per year in the lungs, assuming a uniform irradiation.) Workers in the plutonium process areas are monitored routinely at least every six months, to determine the amount of plutonium that they may have accumulated in the lungs.

An accidental release has the potential of exposing a person to greater than the permissible limit of 16 nanocuries. Persons who may have inhaled air with greater than permissible amounts of plutonium are monitored immediately following the release to determine the exposure status (background or positive) and, if positive, the amount of plutonium in the person's lungs. This monitoring is accomplished using a system called the Body Counter which consists of highly sensitive radiation detectors in a well shielded chamber. The detectors are placed over the subject's upper chest and measure the photons emitted from radionuclides in the body.

In 1980 approximately 4000 body counts were performed. Of these, 90 counts were performed to assess possible inhalations to accidental releases. Four of these persons retained measurable quantities of plutonium in their lungs, but at a level less than 10 percent of the maximum permissible lung burden.

With respect to wound entry of plutonium into the body, at Rocky Flats all cuts, skin punctures, and acid burns that occur in a plutonium process area are measured using a small

scintillator detector that detects the X-rays that are emitted following radioactive decay of the plutonium. If a positive count is seen, the wound is washed to remove the plutonium. Excision of the tissue around the wound is also done if the attending physician determines that excision is warranted. In 1980, 259 wound counts were performed, of which 14 were initially positive. No wound retained detectable quantities of radioactivity following treatment.

Once plutonium enters the body, some of the material may enter the blood and be translocated to other parts of the body. The preferred deposition sites are the bones and the liver. Assessment of the amount of material in parts of the body other than the lung is accomplished by a urine bioassay program. The relationship between the amount of plutonium in the urine and amount of body organs is a time dependent function determined by W.H. Langham.³ This relationship has been modified for chronic exposures and is used to calculate the amount of plutonium in the body organs. This amount is called the systemic burden.

Years of experience in operations at Rocky Flats have contributed to establish control programs which restrict releases of radioactivity from this facility to levels far below that of most other DOE facilities.¹⁶ A typical coal fired power station, for instance, now emits more alpha radiation to the air (around $2 \text{ M } \mu\text{Ci/yr}$)¹¹ than does Rocky Flats. Patients of radioactive diagnostic practices release more radioactivity to waters of the area than does operation of the plant. Even the soil generally contains more natural radioactivity than the plant has contributed outside its boundaries.

Rocky Flats Health Effects On Surrounding Populations

The potential impact of the Rocky Flats Plant associated with both routine and incident related radionuclide emissions has been thoroughly studied and documented in the Plant's Environmental Impact Statement (EIS).¹³ The impact estimates made there take account of all available data on plant emissions and on past accidental environmental releases of radionuclides. Using this data, the EIS concludes that emissions from normal operations of the plant

(assuming a hypothetical year 2000 Denver Metropolitan area population) would result annually in .014 cancer mortalities plus genetic effects. The corresponding impact from the assumed maximum credible plutonium release of 0.1 kg ($3\frac{1}{4}$ lb) is approximately one (1) genetic defect plus cancer mortality per year (over 70 years) in the Denver Metropolitan area year 2000 population. The annual probability of the maximum credible release is estimated as one chance in 7,700,000. The magnitude of the maximum plutonium release has been independently evaluated by the Colorado Department of Health and found to be valid.¹⁷

A comparative idea of the importance of these Rocky Flats related health effects may be obtained from data presented in Report NCRP 45.¹² The estimated average lung and endosteal bone doses to Denver area residents from natural sources and from worldwide fallout may be shown to be ≈ 250 and ≈ 200 mrem/year respectively while the corresponding doses from all radionuclides released by normal Rocky Flats operations are 0.04 and 0.20 mrem/year.¹³ Hence the risk of lung cancer and bone cancer mortality from natural background radiation alone are factors of 6250 and 1000 greater than those expected from plant operations. Considering also (1) that only about 1 percent of all cancers are traceable to background radiation (cf. e.g. Radiation and Human Health by L. Sagan)¹⁸ and that (2) several conservatisms which overestimate the health effects of plant emissions are made in the Impact Statement analysis, the tiny contribution of the plant's operations to area health effects is evident. Additional support of this contention comes from an epidemiological study done on Denver Metropolitan area populations by Dr. C.J. Johnson.¹⁹ As noted by Reissland and Darby²⁰ in commenting on Johnson's work, the cancer incidence in Area Ia (nearest the plant) has statistically the same incidence as in Area IV (the control area farthest from the plant), implying that the increased cancer incidence observed in those areas between Ia and IV is that normally associated with core region/suburban region differences in metropolitan areas.²¹

The total release of plutonium through building exhausts is normally

between 5 and 10 μCi per year.⁷ This alpha radiation can be compared to the alpha radiation in ionization type smoke detectors (5 μCi Am-241)¹⁰ and Colman lantern mantles (near 1 μCi Th per pair), and is far less than the radon emitted from a common clay mine (18 M $\mu\text{Ci}/\text{yr}$).¹¹ Indeed, even the soil in front range areas leads to much higher lung doses from airborne radioactivity (around 100 mrem/yr)¹² than does operation of the Rocky Flats plant (around 1 mrem/yr).¹³

Due to the upstream position of the plant relative to the city of Broomfield, Colorado, water uses at the plant are carefully controlled. For over two years, all process water (water used in plutonium processing areas) has been contained onsite, treated and recycled for use in steam plant makeup or in cooling towers. Solids from this treatment are shipped offsite for burial as radioactive waste. For over a year all sanitary waste water has been recycled on the plant site. Completion last year of a \$2.8 million water diversion and flood control project, now permits the plant to retain all waters (rain and snow, etc.) falling on plant grounds. Three control dams are maintained in a locked shut position and water is released only after monitoring to ensure all drinking water controls are met. Such monitoring in the past has been sufficiently sensitive to note increased natural uranium in annual spring mountain runoff and I-131 from a diagnostic patient who returned to work and used an onsite toilet. Both surface and hydrologic (from a number of test wells about the plant) water samples are shared with the Colorado Department of Health for analytical comparisons. Though no past releases have ever resulted in exceeding any national annual dose guidelines, public concern has been sufficiently great to warrant heavy expenditures to ensure no plant releases can affect downstream communities.

Although current plant operations do not contribute measurable levels of radioactivity to the soil, past practices have not always been so controlled. The largest contribution to environmental soil levels was due to leakage from drums of cutting oil in the 1960's. The total leakage has been estimated from nuclear material balance studies and the analysis of soil activity levels at around 100 grams of plutonium.¹⁴ No soil activity levels

outside the DOE controlled site have been found to exceed the EPA screening level of 200 mCi/km².¹⁵ Though several onsite areas do exceed this level, DOE has made a public commitment to clean up those areas most likely to create difficulty, even though plant personnel assigned to nearby areas have shown no measurable uptakes of plutonium.

The maximum permissible systemic burden is 40 nCi.⁴ This has been determined by analysis of human data which compares the radio toxicity of radium to plutonium.

There have been since the beginning of plant operations in 1952, 26 employees who have accumulated more than 50 percent of the maximum permissible systemic burden while working at Rocky Flats. Sixteen of them are still currently employed. It is a company policy to place these employees on "Radiation Restriction" so they are not exposed to additional amounts of radiation. In addition there have been 49 employees who have received between 25 to 50 percent of the permissible systemic burden. In the past five years, five employees have been added to the category of 25 to 50 percent of the permissible amount and two have been added to the greater than 50 percent category.

The Environmental Impact of Rocky Flats

The operation of a nuclear facility, as in any industry, results in release of some of the material handled at that facility. Due to the nature of the material handled at Rocky Flats, extensive precautions are taken to limit the quantities emitted into the environment. A broad range of monitoring programs are carried out continuously to document these quantities and provide continued information if any unusual conditions should arise. Monitoring starts at each building in which operations are conducted and extends into the surrounding communities. Results of these measurements are reported publicly each month⁶ in a data exchange meeting with the Colorado Department of Health, who also monitors the environment about Rocky Flats. Annual summaries of this environmental monitoring are made to the Department of Energy in Washington, D.C.⁷

The control of air pressure and air

flows is used throughout operational buildings to keep airborne activity out of the workers' breathing zone. This results in large volumes of air which must be treated and monitored daily. Multiple filtration stages exist between the work enclosure, and the final air plenums prior to leaving the building. Live time radiation monitors sample exhaust air to warn of anomalous conditions approaching permissible limits. Particulate samples are also collected at these points three times weekly to document environmental levels. These filter samplers have been demonstrated effective for the collection of particulates of all sizes in numerous studies.⁸ Typical plutonium concentrations found in air leaving plutonium buildings are from $.002 \pm 0.001$ to 0.085 ± 0.01 pCi/m³,⁶ compared to worker breathing air standards of 2.0 pCi/m³ and ambient background in this region of around 0.00001 pCi/m³. The total alpha activity levels typically found in Rocky Flats effluent air are in the range of the alpha activity levels routinely reported in ambient air by the Colorado Department of Health⁹ (i.e. 0.005 pCi/m³). Analysis for other radioactive materials indicates that they are even farther below accepted airborne activity standards.

A third type of evidence which implies minimal plant impact comes from plutonium-in-people autopsy data. As an example, such data^{22, 23} indicates that of the approximately seven tons of plutonium dispersed worldwide by nuclear weapons testing only about 0.25 g (1 part in 28,000,000) currently resides in people. This implies an average burden of about 100 pg (1/10,000,000,000 of a gram) or 8 pCi (8/1,000,000,000,000 of a Curie) for the average world resident. This may be compared to 0.5 μg (.5/1,000,000 of a gram) which is the accepted safe amount of plutonium distributed uniformly through a person's body.²⁴ Further data on persons from the Denver Metropolitan area²⁵ indicate statistically the same amounts of plutonium in their bodies as in those of persons from six other areas of the United States. In this later study, 705 total autopsies were performed with 196 of these done on persons who had resided in the Denver Metropolitan area. Another autopsy study has been done on Denver area residents with the specific intent of establishing whether residents near the

Rocky Flats Plant have amounts of either total or Plant originated plutonium in their bodies. While no final report has been issued for this study, a preliminary review of the data²⁶ indicates near-plant residents have no significantly greater amounts of total plutonium in their bodies than persons from a control area remote from the plant.

Thus, to summarize, even though significant quantities of radionuclides are handled at the Rocky Flats Plant¹³ and there have been past environmental releases of plutonium,¹³ the overwhelming preponderance of evidence shows the health effects to surrounding populations from both routine operation and predicted "maximum credible accidents" would be indistinguishable from such effects which occur naturally in area populations.

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³ Langham, Wright H., "Determination of Internally Deposited Radio-Active Isotopes from Excretion Analysis," *American Industrial Hygiene Association Journal*, 18, 3, 305-318, September, 1956.

⁴ "Permissible Dose for Internal Radiation," Report ICRP No. 2, International Commission on Radiological Protection, 1959.

⁵ Putzier, E.A., "Radiation Standards and the Control of Radiation Exposure," Vol. 77, No. 4, *Colorado Medicine*, April, 1980.

⁶ Rocky Flats Plant Monthly Environmental Monitoring Report, EAC-376110-079, December, 1980.

⁷ Rockwell International Annual Environmental Monitoring Report, RFP-ENV-79, April 10, 1980.

⁸ Eisenbud, M., *Environmental Radioactivity*, Chapter 17, Academic Press, New York, 1973.

⁹ Colorado Department of Health Environmental Surveillance Report on USDOE Rocky Flats Plant, December, 1980.

¹⁰ "Radiation Exposure from Consumer Products and Miscellaneous Sources," National Council on Radiation Protection and Measurements, Report NCRP 56, November 1, 1977.

¹¹ "Radiological Impact Caused by Emissions of Radionuclides Into Air in the United States," Environmental Protection Agency Report EPA 520/7-79-006, August, 1979.

¹² "Natural Background in the United States," National Council on Radiation Protection and Measurements Report NCRP 45, November 15, 1975.

¹³ "Rocky Flats Plant Site Final Environmental Impact Statement," U.S. Department of Energy, Report DOE/EIS-0064, April, 1980.

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Dermabrasion: An Effective Treatment for Acne and Its Aftermath

Brenda Hume, BA, Fort Collins, Colorado

Acne is a by-product of chocolate or colas.

Today it is known that this statement isn't true. Unfortunately, many people still believe this myth along with another one... that acne is a "stage" which people eventually grow out of. Not true. Many people suffer with severe, chronic acne well beyond their 20's into their 30's and 40's. And some never "grow" out of it.

Severe acne is difficult to treat. If antibiotics, steroid injections, and topical drugs are not successful, there are often few alternatives. However, a procedure called dermabrasion can significantly reduce the frequency and size of breakouts in many cases. Dermabrasion also is used to treat acne scarring.

Surgical dermabrasion (planing) is a procedure in which a high-speed, abrasive instrument abrades or planes the skin. Though the procedure was not extensively used in medical practice until the 1950s, the basic technique has existed for more than 1,000 years. In 1550 B.C., pumice was used to rub the skin raw. As healing progressed, the skin developed a new outer skin layer (epithelium) that was smooth and unblemished.

Therapeutic Values

Though the reason is unknown, new acne lesions are found much less often in abraded than in unabraded skin. Some surgeons report dermabrading is the most effective, single treatment for active acne vulgaris (the most common acne form).¹

Dermabrasion won't help all types of scarring. Deep scars or ice-pick form scars do not respond well. When a new layer of skin develops (reepithelialization), it regenerates from pilosebaceous units (Figure 1). Ice-pick scars are deeper than the level of pilosebaceous units. Dermabrading to this depth would lead to additional scarring.

Best results are obtained from flat, broad-based scars or raised, linear scars. The raised portion is flattened and the border of the scar blends with the surrounding skin. Broad-based scars ex-

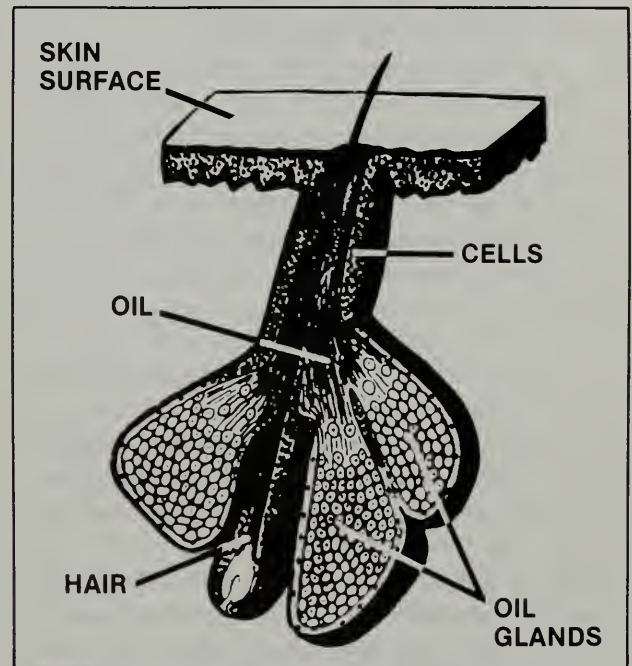


Figure 1. Scars extending further than the level of this pilosebaceous unit cannot be abraded. Dermabrading to this depth would lead to additional scarring.

tend to a depth that can be abraded safely. Whether or not scarring will benefit from abrading can be answered only by a physician who does dermabrasion.

Besides treating acne and its aftermath, dermabrasion is useful in the treatment of other conditions such as precancerous skin, sun warts—growths that may lead to skin cancer, pigmented moles and rhinophyma (enlarged nose from acne rosacea).

Risks/Complications

Risks are relatively few, complications usually minor. The chief risk is hyper- or hypopigmentation. The response of pigment to abrasion is unpredictable and can result in a splotchy appearance. Least affected are light or dark skin types. Middle-shaded skin found in olive-skin types, orientals, brunette caucasians, and tan negroes carries the highest risk.

The epidermis (outer layer of skin) of extremely

dark skin contains a maximum amount of pigment and is not notably affected by slight metabolic (chemical) changes after dermabrasion.

Conversely, white skin has an epidermis that has, for the most part, a limited potential to produce pigment. Rarely does a visible amount of pigment develop after abrasion.

Middle-shaded skin types have the potential to produce excess amounts of pigment in response to injury. If abrasion stimulates pigment production, the skin darkens. Or if pigment is not distributed evenly, lightening may occur.

Scarring from the procedure itself is another risk, though rare. Infection also occurs infrequently. When infections have developed, patients were usually in a hospital environment. Postoperative care was of an open-air type without dressings. Speculation is that the high bacterial count of the hospital ward triggered the infections.

Complications include milia, acneform lesions, and erythema (redness). Milia are the remnants of oil gland ducts and resemble whiteheads. Occurring in about 50 percent of abraded patients, they appear within two weeks postoperatively. The physician can remove them, thus milia are only a temporary problem.

Acneform lesions are a frequent complication. Appearing as a mirror-image of a recurrence of acne, the patient is disappointed. Actually, this is tissue debris left behind by the planing and usually clears spontaneously in seven to ten days.²

All patients will experience redness (erythema) of varying degrees. This normally lasts two to three weeks or in some cases, as long as twelve. Cosmetics can adequately conceal the redness until it fades.

Psychological Aspects

Although most people are awake during the operation, dermabrasion is not considered a minor procedure. Patients literally have their skin rubbed off. In addition, the surgery is performed around the area of the nose, eyes, ears and mouth. The sound of the abrader, the sting of a cold spray, and the sight of skin debris, requires a strong psychological commitment to the procedure by the patient.

Following the surgery, the face looks injured rather than treated. The area is bloody and

begins to swell. After the bleeding stops, tissue fluid oozes for 20 to 30 minutes.

The healing time is a period of uncertainty. One or more weeks elapse before healing is complete and only after approximately six months can improvement be precisely defined. Support and reassurance are essential to relieve the distress during this time.

Patients also face the possibility of further abrading. More than one procedure often is necessary. Scarring can reach the innermost layer of skin. A physician can abrade to a reasonable depth, but in many cases scars will be deeper than what can safely be planed. The initial surgery yields the most improvement. A second or third procedure can further reduce remaining scar depth.

Procedure

Dermabrasion generally is done on an outpatient basis. Upon arrival at the physician's office, preoperative medication (Demerol or Valium) is given to reduce anxiety. Next, Xylocaine injections are administered to numb the skin. A cold anesthetic agent (freon) is sprayed on the first skin patch to be abraded. There is a slight sting when the spray meets the skin.

The freon freezes the skin to a board-like hardness. When the surgeon applies the abrader, only a slight pressure is felt.

When the last area has been abraded, the patient rests for 20-30 minutes before the treated sites are dressed. He then returns home to begin the 10-day recuperation.

Who Does Dermabrasions?

Most plastic surgeons and some dermatologists perform dermabrasions. Hospitals or medical societies are a helpful reference for people seeking a reputable and qualified physician.

Overall Value

Dermabrasion is a useful tool in treating chronic acne and resulting scars. To the physician, it represents another therapy mode. But to the patient, dermabrasion gives hope ... that acne breakouts and scars will become less noticeable, and as a result, facilitate an improved self-image.

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Surgery for Morbid Obesity

*Comparison of Gastric Bypass With Vertically Stapled Gastroplasty**

Gifford V. Eckhout, MD, and J. Frederick Prinzing, MD, Denver, Colorado

Surgery for morbid obesity has been developed in the past twenty years because of the failure of medical management in the vast majority of patients. Morbid obesity presents serious problems to the patient, both physical and psychological. VanItallie and Drenick¹ state that the mortality rate for the morbidly obese is up to eleven times higher than it is for persons of normal weight. This paper compares 83 Mason gastric bypasses (GB) as modified by Alden², with 90 vertically stapled gastroplasties (VSG) in the treatment of morbid obesity.

Historical Background

Considerable changes in surgery for morbid obesity have occurred in the past twenty years since Payne, DeWind, and Commons³ introduced various intestinal shunts to induce weight loss. While jejunoileal bypass produced satisfactory weight loss, the operation has been largely abandoned because of a high incidence of early and late complications.

In 1969, Mason and Ito⁴ reported their experience with gastric bypass. In 1975, using stapling instruments, Alden² modified Mason's gastric bypass (Figure 1). The modification decreased both the morbidity and mortality as well as the time required to accomplish the operation. Because of some disturbing features of gastric bypass, namely, the incidences of dumping syndrome, the appearance of iron deficiency anemia, marginal ulcer with hemorrhage, sometimes massive, stomal obstruction, afferent limb syndrome, symptomatic bilious gastritis, later stomal enlargement, acute distal gastric dilatation and rupture, staple line failure, and inadequate

weight loss in 10 to 20 percent of reported cases, and the inability ever again to examine the distal stomach by noninvasive techniques, the author instituted a study of vertically stapled gastroplasty in an attempt to eliminate some of these problems and still produce adequate weight loss.

Subjects and Methods

Patients were selected for surgery on the basis of being at least 100 or more pounds over ideal weight and being free of any major contraindications of major surgery. Intractable peptic ulcer disease or alcoholism were included as absolute contraindications to surgical treatment. Their age range was 15 through 63 years. All had demonstrated inability to lose weight by medical management, and all had been morbidly obese for several years. All patients underwent a thorough history and physical examination, blood count, urinalysis, blood chemistry studies, bleeding and clotting studies, chest roentgenogram, electrocardiogram, upper gastrointestinal x-rays, gall bladder studies and thyroid function study. All patients received detailed counseling regarding gastric surgery for morbid obesity.

Patients in the GB group had an average weight of 251½ pounds, and those in the VSG group, 273¼ pounds. Average heights were 5 feet 4¼ inches and 5 feet 6 inches respectively. Average age for both groups was 36 years.

All patients received 1 gram of cefazolin sodium intramuscularly 2 hours before surgery and every 8 hours for 72 hours after surgery. Subcutaneous heparin sodium was given to all patients except 30 patients in the GB group and 67 patients in the VSG group, beginning with 4000 units 2 hours prior to surgery, and every 8 hours thereafter until discharge from the hospital. The total of 97 patients from both groups who did not receive heparin sodium demonstrated a low anti-

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thrombin III prior to surgery and were treated with 2 mgm of coumadin daily for 4 or 5 days before surgery and for 30 days following surgery.* All patients in each group had a sump drain in place which was removed on the 4th postoperative day.

The technic used for gastric bypass was described by Mason⁴ and modified by Alden² (Figure 1).

The technic used for VSG is similar to that of the Gomez gastropasty⁵ (Figure 2) in which the TA 90 stapler is applied twice transversely across the fundus forming a 50 cc gastric receptacle and leaving a 12 mm channel on the greater curvature (in VSG, a 10 mm channel is formed on the lesser curvature). To prevent later enlargement of the channel and subsequent weight gain, Gomez stabilizes the greater curvature channel with an encircling heavy chromic catgut suture, a circumferential seromuscular 2-0 polypropylene suture, and an encircling, inverting row of interrupted nonabsorbing Lembert sutures. In the VSG, the same technic and principles apply, with the exception that the TA 90 stapler is applied twice in vertical fashion, parallel to the lesser curvature, forming a 50 cc gastric pouch with the channel on the lesser curvature. Since the stapler is applied vertically, none of the blood supply to the fundus need be destroyed and therefore a running 2-0 polypropylene suture can safely be used to encircle and reinforce the TA 90 staple lines without fear of causing necrosis and perforation of the fundus. The running polypropylene suture helps to decrease the incidence of later staple line failure.

The first step of VSG is the passage of the surgeon's index finger through the avascular area of the lesser omentum over the caudate lobe of the liver and introduction of the finger into the lesser omental bursa. Next, a window is made in the avascular portion of the gastrophrenic ligament just above the greater curvature of the stomach and just to the left of the esophagus. A window is then made in the lesser omentum close to the gastric wall, midway on the lesser curvature of the stomach (Figure 3). These two windows are connected with a red rubber #18 urethral catheter to which is attached the toe of the TA 90 (Figure 4) from which four staples have previously been removed from the heel of the cartridge (opposite from the pin). The use of the urethral catheter in this way allows for safe and easy application of

the TA 90 stapler. The TA 90 is applied twice in vertical fashion, parallel to the lesser curvature placing the TA 90 staple lines quite close together (Figure 5). The removal of 4 staples from the end of the TA 90 cartridge produces a channel on the lesser curvature when the stapler is fired. The next step is the placement of a running 2-0 polypropylene suture to encircle the two TA 90 staple lines including both the anterior and posterior gastric walls (Figure 6). At the lower end of the TA 90 staple lines, a #1 chromic catgut suture is placed through the stomach and tied over a previously placed #30 (10 mm diameter) tapered rubber Maloney esophageal dilator which the anesthesiologist has passed through the esophagus into the stomach and through the channel on the lesser curvature (Figure 6). The 2-0 polypropylene suture is then run around the channel as a continuous seromuscular stitch turning in the lesser curvature gastric wall covering the #1 chromic suture and forming a "pseudopylorus" on the lesser curvature gastric wall (Figure 7). A layer of interrupted silk Lembert sutures is next placed around the channel to accentuate further the "pseudopylorus" (Figure 8). The dilator is removed and a nasogastric tube is placed in the 50 cc pouch. Fifty cc of saline is forced into the pouch to test the size of the pouch and also to test for any leaks. Then the nasogastric tube is placed through the channel into the distal stomach. It is removed at 48 hours and clear liquids at the rate of 30 cc every 30 minutes are begun at 72 hours postoperatively. In an attempt to minimize pulmonary complications, all patients are ambulated and are given respiratory therapy every 3 hours, day and night, for the first 24 hours after surgery, every 4 hours for the second 24 hours, and every 6 hours for the 3rd through 5th days. The head of the bed is elevated to 30 degrees continuously to facilitate breathing. With this regime it has been found unnecessary to place patients in the intensive care unit in 98 percent of cases. The GB patients were begun on a soft diet at discharge from the hospital. Following the advice of Pace *et al*⁶, VSG patients are dismissed from the hospital on a full liquid, 500 calorie diet in three small feedings per day for 90 days. A soft diet is begun at the end of 90 days. All patients were followed at 4-12 week intervals. Laboratory studies were ordered only if indicated. All patients were given multiple vitamins daily postoperatively. VSG patients were given chewable or liquid preparations of multiple vitamins since tablets will cause obstruction of the channel.

*The relationship of morbid obesity and the antithrombin III level is currently being studied.



Figure 1. Mason gastric bypass as modified by Alden.



Figure 2. Gomez gastroplasty.

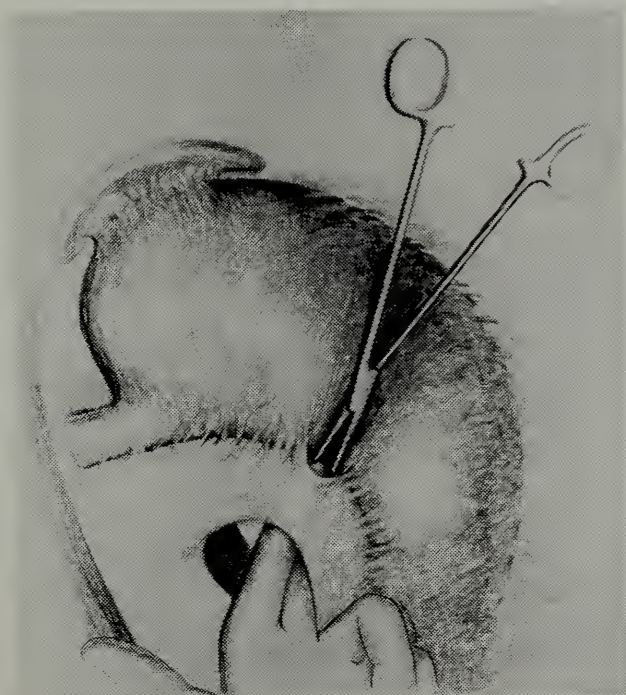


Figure 3. With the finger through the opening in the lesser omentum, at the mid-portion of the lesser curvature, a window is made close to the gastric wall through which the TA 90 is introduced.



Figure 4. #18 Urethral catheter placed to facilitate application of TA 90 stapler.

Results

The average postoperative stay was 7.8 days for the GB group and 5.8 days for the VSG group. The average operating time was 80 minutes and 65 minutes respectively. Concurrent cholecystectomy was performed 9 and 19 times respectively. Concurrent hiatal hernia repair of the Allison type was performed on no patients in the GB group and on six patients of the VSG group. The three month average weight losses were 46½ pounds and 55⅔ pounds respectively (see Table I). The average six month weight loss was 64 pounds and 74 pounds respectively. The median weight loss at three months was 18 and 20 percent respectively. Median weight loss at six months was 25 and 27 percent respectively. Median weight loss for GB at twelve months was 31½ percent. The average weight loss for GB at twelve months was 77 pounds. The followup on VSG is not long enough for twelve month results to date.

Complications

There were no deaths in either group. In the GB group there were eleven wound infections, two incisional hernias, eight splenectomies, twelve staple line failures, one small bowel obstruction, two nonfatal pulmonary emboli and two mild dumping syndromes (see Table II). One patient developed massive hemorrhagic gastritis, afferent loop obstruction and acute distal gastric dilatation and required emergency 90 percent gastric resection on the eleventh postoperative day. In this critically ill patient it was not necessary to dismantle the gastrojejunostomy and he made an uneventful recovery and has maintained satisfactory weight loss. Only one patient in the GB group has required rehospitalization for excessive vomiting. At 12 months postoperatively six patients in the GB group have inadequate weight loss (less than 60 pounds). Of the twelve patients with staple line failure, all twelve have been restapled and are continuing to lose weight satisfactorily. The one patient who developed a bowel obstruction was seen twelve months after GB surgery. At surgery an internal hernia behind the anterior gastrojejunostomy was successfully reduced.

In the VSG group there were eleven wound infections, one splenectomy, two staple line failures, (one complete, and one very small—not interfering with weight loss) (see Table II). Six patients have required rehospitalization for excessive vomiting. All six were found to be hypokalemic. Of the six patients, barium swallow was done on each and each proved to have a patent channel. Treatment for excessive vomiting has consisted of intravenous cimetidine, intramuscu-

lar prostigmine, hydration, potassium replacement, limited oral intake, and oral concentrated antacids in small volume dosage. All six patients have responded to this regime in a matter of two to five days. No patient in the VSG group has required either dilation or reoperation for obstruction. Marginal ulcer has not been seen in either group. There have been no cases of leaks, peritonitis or intra-abdominal abscess in either group. In the GB group, eight patients have been rehospitalized for cholecystectomy for gallbladder disease following GB. In the VSG group no patient to date has required cholecystectomy following VSG.

| | GB (83 Patients) | | VSG (90 Patients) | |
|-----------|-------------------|-------------|--------------------|-------------|
| | Pounds (Kg) | % of Pre Op | Pounds(Kg) | % of Pre Op |
| 3 months | 46 (21) | 18% | 56 (25) | 20% |
| | 83 Patients | | 76 Patients | |
| 6 months | 64 (29) | 25% | 74 (34) | 27% |
| | 83 Patients | | 37 Patients | |
| 12 months | 77 (35) | 31% | | |
| | 52 Patients | | | |

| | GB (83 Patients) | VSG (90 Patients) |
|---------------------------------|------------------|-------------------|
| Deaths | 0 | 0 |
| Staple line failure | 12 | 2 |
| Reoperated | 12 | 0 |
| Inadequate weight loss | 6 | 1 |
| Splenectomy | 8 | 1 |
| Wound infection | 11 | 11 |
| Rehospitalization for vomiting | 1 | 6 |
| Leak, peritonitis | 0 | 0 |
| Acute distal gastric dilatation | 1 | 0 |
| Massive gastric hemorrhage | 1 | 0 |
| Afferent loop obstruction | 1 | 0 |
| Pulmonary embolus | 2 | 0 |
| Mild dumping syndrome | 2 | 0 |

Comment

Comparison of GB with VSG reveals that the latter operation requires less operating time, and involves fewer and less serious complications. Postoperative hospital stay is also shortened. Patients in the VSG group were noted to have an easier postoperative course with more rapid recovery.

Vomiting occurred more frequently with VSG. Strict adherence to the liquid diet during the first three postoperative months greatly decreased the incidence of vomiting. In addition to vomiting, patients who persisted in overeating often complained of nausea and chest or epigastric pain. These symptoms were generally relieved after reiteration of the importance of avoiding overdistention of the small pouch and of chewing the food well after beginning a soft diet. While excessive vomiting has only occurred in 6.6 percent of the VSG group, it has created a frustrating problem in those individuals. Frequent counseling re-

garding diet and reassurance has been necessary. In these patients a liquid diet taken in frequent small quantities must be followed until the tendency to vomit subsides, which may be a period of up to 6 months. In these individuals treatment for recurrent vomiting has consisted of in addi-

tion to repeated diet instruction, cimetidine in liquid form, mild sedatives and antacids. All six patients have responded without resort to any surgical maneuver.

On the basis of this study it appears that many of the disturbing features of GB, as mentioned

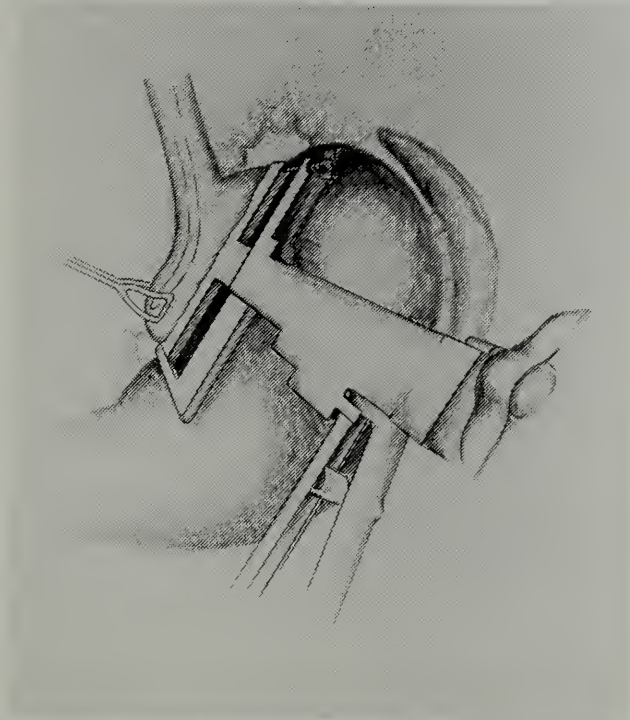


Figure 5. TA 90 stapler applied vertically parallel to the lesser curvature forming a 50 cc pouch. Note NG tube out of harms way. 4.8 mm staples are used in both GB and VSG.

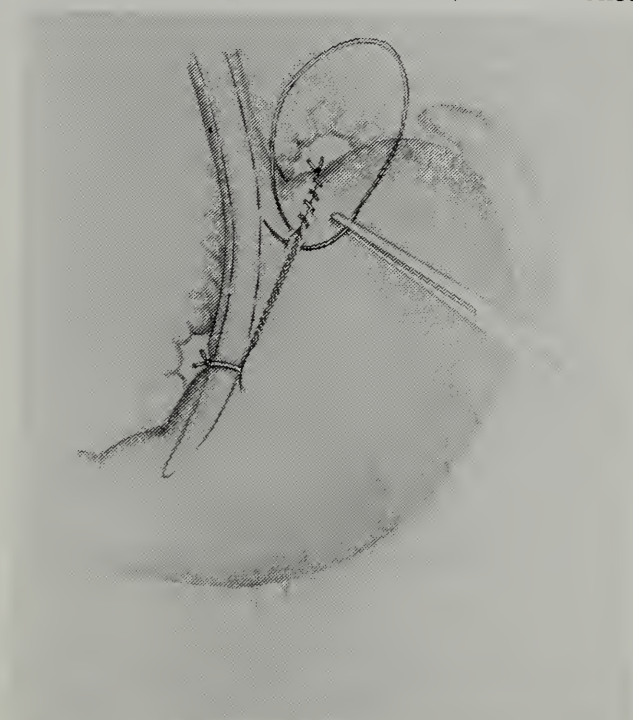


Figure 6. Running 2-0 polypropylene suture encircles all TA 90 staple lines and includes anterior and posterior gastric wall bites. #1 chromic suture tied over #30 dilator.



Figure 7. Continuous seromuscular running 2-0 polypropylene suture around channel forms "pseudopylorus."

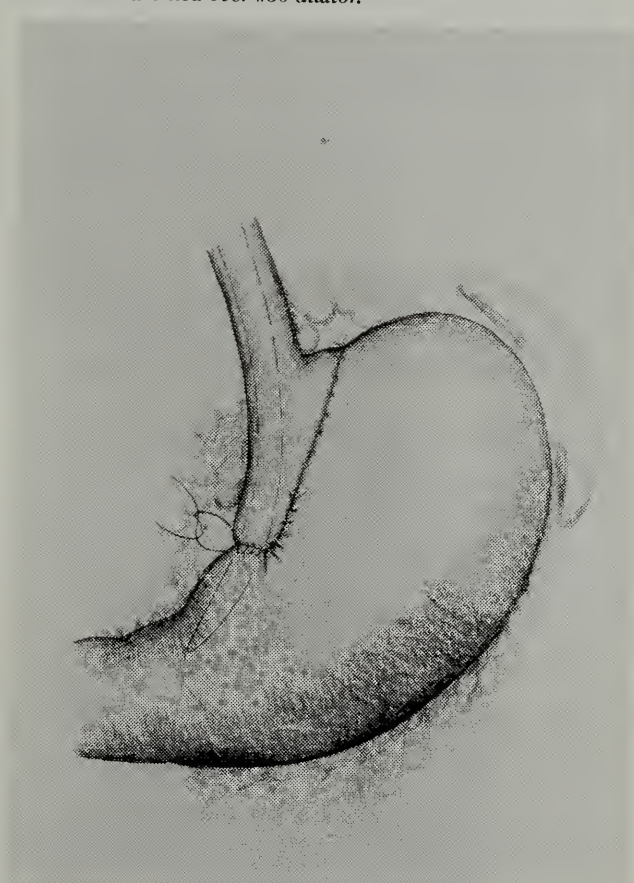


Figure 8. A layer of interrupted nonabsorbable Lembert sutures around channel accentuates "pseudopylorus."

(Continued from page 120)

earlier, are decreased or eliminated by VSG. Avoidance of gastrotomy and gastrojejunostomy decreases morbidity and mortality. Dumping syndrome, marginal ulcer, afferent loop problems, and symptomatic bilious gastritis are eliminated. Prophylactic gastrostomy, associated with GB, done to prevent acute massive distal gastric dilatation and rupture of the stomach⁷, is not necessary.

A significant contributing factor to the problem of inadequate weight loss in all gastric stapling operations for morbid obesity is staple line failure. To decrease this incidence, surgeons have tried applying the stapler twice instead of once, and have also reinforced the staple lines with sutures. However, as pointed out by DeLucia⁸, these additional steps greatly increase the incidence of leaks, perforations, and necrosis of the stomach. DeLucia found in GB that, if a double application of the TA 90 stapler were made transversely across the fundus and then the staple lines were encircled with sutures, the perforation rate increased to 16 percent; in this situation, the high incidence of perforation is thought to be due to devascularization of the fundus, since the blood vessels of the upper third of the greater curvature are taken down during GB and viability of the fundic pouch then depends mainly on the upper branch of the left gastric artery. However, in VSG, no blood vessels to the fundus are sacrificed and hence the fundus remains viable, which allows one to apply the TA 90 twice and to also reinforce the staple lines with suture in an effort to decrease the incidence of staple line failure. Indeed, in this study, staple line failure occurred in 14 percent of the GB patients, who had a single staple line, and in only 2 percent of the VSG patients, who had a double staple line encircled with sutures.

Another persistent problem with all types of gastric stapling operations for morbid obesity is the tendency of the outlet of the small fundic pouch to dilate and allow the patient to gain weight again. The support of the outlet with encircling sutures as used in VSG (which is similar

to that used in the Gomez gastropasty), appears in this short followup to maintain a small enough outlet to prevent weight gain. Since the wall of the lesser curvature of the stomach is thicker than the wall of the greater curvature, the "pseudopylorus" placed on the lesser curvature may be less likely to dilate and also less subject to trauma and subsequent perforation than a "pseudopylorus" constructed on the greater curvature. With the channel placed in line with the magenstrasse on the lesser curvature in the VSG, it is relatively easy to use a gastroscope on these patients and also to place a nasogastric tube into the distal stomach, should this be desirable. Also, contrast media can be used at anytime to examine the distal stomach, pylorus and duodenum, which is not possible in the GB patient.

In this admittedly short followup of VSG patients, weight loss has thus far equalled that seen in the GB patients. Only a longer followup will determine if the weight loss will be as lasting as that seen with GB.

Conclusion

On the basis of this study comparing GB with VSG, the latter operation has fewer and less serious complications than seen with GB. Recovery is more rapid with VSG and postoperative hospital stay is shortened. Those problems with GB which are due to the necessity of forming a gastrojejunostomy are eliminated. Patient satisfaction is equally good with either operation. The ease with which gastroscopy and x-ray studies of the distal stomach, and placement of a nasogastric tube into the distal stomach can be accomplished are additional advantages over GB. If weight loss, on longer followup, continues to be equivalent to that obtained with GB, then VSG will offer the morbidly obese patient a safer and more physiologic answer to his problems.

ADDENDUM:

At the time of printing, the above study includes 140 VSG patients with no mortality. Twelve month average weight loss figures are equal at 32% of preoperative weight for both GB and VSG.

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Preoperative Psychiatric Evaluation

Gastric Exclusion Surgery for Morbid Obesity

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Preoperative psychiatric evaluation of morbidly obese candidates for "stapling" gastric exclusion permits protective assessment of motivation and requisite patient responsibility for long-term outcome. Experience discounts the need of psychiatric consultations in all cases, and the relevance of psychiatric problems, per se, to outcome. Motivation, coping capacity, and patient commitment to abrupt and long-term behavioral change appear central to constructive surgical intervention.

Surgical intervention for morbid obesity has escalated in the past two years, encouraged by the development of "stapling" gastric exclusion techniques. These, in contrast to earlier "intestinal bypass" procedures, have demonstrated

Figure 1. Stapled off 60 cc. size upper gastric pouch is shown. Esophagus enters at top of pouch and 12 mm. channel drains pouch inferiorly into main body of stomach.

Figure courtesy of Dr. Eckhout



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greater effectiveness in weight reduction over two years with brief postoperative morbidity and little risk of the earlier troublesome nutritional and physiologic dyscrasias. Weight reduction of 35 to 45 kg. (85 to 100 lbs) is common within the first year, plateauing in the second—this with surprising muting of subjective hunger despite the abruptly curtailed food intake. One modified surgical technique is outlined below (box):

Gastric Exclusion Stapling (Fabito/Eckhout technique)

Gastric stapling for treatment of morbid obesity results in the formation of a small (less than 60 cc. [2 oz.] reservoir). It is accomplished by using the TA-90 autosuture stapling instrument. By removing four staples from the end of the stapler cartridge on the lesser curvature side of the stomach, a 12 mm. channel is formed to drain the small reservoir (Fabito technique, as modified by Eckhout).^{3,5}

The small pouch thus created fills rapidly on ingestion and gives the patient a feeling of fullness and satiety. The reduced caloric intake results in an average 3.6 to 5 kg. (8 to 12 lbs.) weight loss per month, stabilizing after about eighteen months at approximately 40 percent average loss from preoperative weight. Equilibrium is apparently established by gradual, limited dilation of the pouch and by behavioral/metabolic adaptation.

Patients are ambulatory on the same day of surgery and are usually discharged on the sixth postoperative day (on 500 cal. liquid diet for sixty days, soft to regular diet within ninety days postoperative, with supplementary vitamins).⁴

The preliminary nature of outcome-assessment at this time is evinced by the lack of reports in the literature establishing benefit sustained two and three years postoperatively, such documentation necessarily awaiting cumulative experience with a new technique. Most of the few reports to date encompass only the first months and year: Halmi, Stunkard, and Mason have observed postoperatively "far fewer emotional disturbances than [patients] had experienced during earlier weight losses by dieting," abetted by their "heightened satiety."⁶ Saltzstein and Gutmann cite patients' typically describing "feeling 'full' with one-fourth of a normal serving . . . This barrier to overeating is passive, as opposed to dieting and/or behavior modification . . . The majority of patients (80 percent) either continue to do well or improve from a psychological standpoint, as demonstrated by MMPI assessment after weight loss." (Length of postoperative interval is not stated but implied to be six to twelve months.)⁷

A two year followup study (N=29) published this year by Halmi, Stunkard and Mason concludes that over half of their series "reported that surgery was followed by a greater measure of positive emotions than they had experienced during dietary treatment . . . 'much more' elation and self-confidence."⁸

The major finding of this study is that gastric bypass produced large weight losses in severely obese people with far fewer emotional disturbances than had accompanied weight loss achieved earlier by diets.⁸

The fat person stereotype

*Let me have men about me that are fat . . .
Yond Cassius has a lean and hungry look@*

Popular stereotype has it that the very fat person is a jovial, outgoing, unruffled entity—in simplistic contrast to Shakespeare's Cassius. But when maternal or avuncular plumpness inflates to double or triple normal weight, mechanical realities alone impose unhealthy burdens upon orthopedic, cardiovascular, respiratory, and biochemical systems—quite in addition to body-image impact psychologically. A hapless victim of diminishing mobility and interpersonal involvement, the erstwhile "jolly" fat person compounds his bulimia with frustration and seclusiveness—perpetuating a tragic habit pattern toward morbid outcome.

Societal "marality": surgery for malbehavior?

Society's puritan ethic recoils from the medical profession's rescuing miscreants whose illnesses are presumed to stem from behavioral weakness or excess. The Cotton Mathers among us at least subliminally punish sin by stigmatizing illnesses which arise from such abuses as alcohol, drugs, sex, or even excess calories. Special rules, for example, limit third-party coverage of elective abortion, psychotherapy, breast augmentation, and psychosurgery—in contrast to actuarial largesse for "innocent" victims of chance, circumstance, or careless accident.

Clinical insight into the plight of morbidly obese patients readily erodes the simplistic assumption that "they just shouldn't eat so much." Beyond faulty habit-patterns are multiple other factors (*e.g.*, familial, hypothalamic, metabolic, and idiosyncratic hyperabsorption) which give us pause before we judgmentally indict these victims.

Preoperative psychiatric assessment

Predicting outcome poses thorny problems for the psychiatric consultant—however laudable may be his recruitment preoperatively by the cautious surgeon. By analogy, our expertise in predicting "dangerous" of a parolee's long-term behavior is historically suspect! With appropriate humility we may offer educated guesses on the basis of mental status evaluation, but it is doubtful that even the diagnosis of a specific psychiatric disorder has relevance to patient motivation or outcome of surgery. Saltzstein and Gutmann have observed:

Gastric bypass surgery specifically prevents overeating, and, therefore, specifically blocks this emotional response to a stressful life circumstance. This barrier to overeating is passive, as opposed to dieting and/or behavior modification, and may account for the relatively good psychosocial outcome noted by us.

. . . In general, gastric bypass surgery resulted in a positive psychological outcome regardless of the extent of psychopathology demonstrated preoperatively.⁷

More useful to the referring surgeon (than a psychiatric diagnosis is the psychiatrist's (a) assessment of the patient's motivation and insight into the procedure and its rationale, and (b) assuring the patient's acceptance of long-term responsibility for constructive adaptation to me-

chanically enforced oral deprivation, for finding healthier channels for his compulsivity.

This writer's experience in preoperative evaluations in excess of one hundred cases in eighteen months has evolved a suggested check-list, subject, of course, to exceptional problems and ongoing refinement:

(1) *Indications.* Obesity of twice or more than ideal weight (*i.e.*, 45 kg. [100 lbs.]) unless additionally justified by co-existent disease thereby aggravated (*e.g.*, hypertensive and circulatory problems, diabetes mellitus, hiatus hernia). Failure of conservative efforts toward weight reduction. Autogenous motivation for normalized weight (not unduly pressured by others).

(2) *Psychosocial history.* Familial and developmental patterning, body-image identifications. Past capacity to cope with losses, stress, and major surgery.

(3) *Mental status examination.* In addition to standard assessment of topical, affective, and comprehensive factors, special vigilance about ambivalent motivation, unrealistic goals and undue reliance upon permanent mechanical effects of surgery.

(4) *Preparatory orientation.* Validation of therapeutic alliance and commitment, consistent with realistic expectations. Understanding of rationale, procedure, and mechanical consequences of surgery. Readiness to cope with anxiety of change, in adapting to spare-eating, to a gastro-nomic life-pattern different from that of one's peers and food habitues. Awareness of possible impact of normalized weight on personality, spouse, and peers.

Results

Two of the (N=100+) referred cases elicited psychiatric recommendation against surgery (but, significantly, had already been so adjudged by the surgeon and consulting internist). One was hypomanic, inordinately demanding of surgery unrealistically as an answer to multiple physical disabilities; the other was highly ambivalent about surgical intervention which has been pressed by family and peers. Four other patients were accorded additional discussion and study because of earlier psychiatric decompensations and unstable marital situations—their postoperative and convalescent courses have been entirely uneventful. One patient who presented no preoperative concern psychiatrically, required readmission six weeks later for vomiting, dehydration, and transient electrolyte imbalance following an acute influenza-type infection with

considerable anxiety; she responded to medical support and brief psychotherapeutic reassurance.

Conclusions

To date, two surgeons performing gastric exclusion have required preoperative medical and psychiatric consultations for concurring opinions in all cases. Medical clearance seems clearly mandated for each case, but our experience indicates that routine psychiatric screening is not necessary and is less than cost-effective for most candidates. More selective psychiatric referral appears appropriate as experience with the procedure accumulates followup data of outcomes. Candidates for the surgery who have history of prior psychiatric decompensations, who have highly unstable situational adjustments, who have clinical ambivalence or unrealistically high expectations, and those under pressure of others to have the surgery can well be referred for psychiatric assessment and preoperative counseling.

Our experience supports the observation earlier reported: *viz.*, that, paradoxically, most candidates for gastric exclusion surgery who have recognized personality problems seemed even more likely to benefit from surgical rescue than were the occasional "normal" morbidly obese patients—some of whom manifested occasional problems of adaptation postoperatively.

Clinical study of morbidly obese patients in general adds credibility to their assertions that many really "don't eat that much,"—that their inordinately efficient digestive system create a dilemma of helplessness in a morbid life style and progressive handicaps.

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CONTINUING MEDICAL EDUCATION CALENDAR

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April

22 AN ANALYSIS OF BLUE CROSS/BLUE SHIELD CLAIMS DATA TO ASSESS THE EFFECTS OF MENTAL HEALTH SERVICES ON MEDICAL COSTS. Department of Preventive Medicine, University of Colorado Health Sciences Center, Campus Box C245, 4200 E. 9th Ave., Denver 80262. 394-5177.

22 ISCHEMIC HEART DISEASE: A RATIONAL APPROACH TO TREATMENT. Julesburg, CO. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Ave., Denver, CO 80202. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

22 REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE. Department of Radiology, University Hospital, Denver, CO 80262. Contact: Suzanne Warner, 394-7773. (3 hours of AMA Category 1 credit).

23-25 TEACHING AND COUNSELING STRATEGIES IN ADULT AND ADOLESCENT SEXUALITY. Rocky Mountain Planned Parenthood, Inc., 2030 E. 20th Ave., Denver. Contact: Debbie Casselman, RMPP CCE, 1525 Josephine, Denver 80206. 321-2471. (20 hours of CME credit).

24 RECOGNITION AND TREATMENT OF PNEUMONIA. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

24 THE CHILDREN'S HOSPITAL ORTHOPEDIC DAY. Location to be announced. Contact: Dr. Robert Eilert, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6600.

25 RMPP/PPFA WESTERN REGION MEDICAL SEMINAR. Plaza Cosmopolitan Hotel, Denver. Contact: Barbara Knize, M.D., Rocky Mountain Planned Parenthood, 1525 Josephine Street, Denver 80206. 321-2400. (6½ hours of Continuing Medical Education).

30-5/2 ARRHYTHMIA DIAGNOSIS AND MANAGEMENT FOR THE NON-CARDIOLOGIST. The Inn at Loretto, Santa Fe, New Mexico. Contact: Barry Ramo, M.D., 201 Cedar, SE, Suite 604, Albuquerque, New Mexico 87106. 242-2796. (18 hours of AMA Category 1 credit; 18 hours of AAFP credit; 18 hours of ACEP credit).

30-6/2 CONTROVERSIES 2: An Ongoing Course in the Practice of Pediatrics. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver 80218. 861-6947. (AMA credit available on an hour-by-hour basis).

May

1 INTERPRETATIONS OF ROENTGENOGRAPHIC IMAGING. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

4-8 THE DENVER POSTGRADUATE INSTITUTE IN EMERGENCY MEDICINE: MEDICAL AND TOXICOLOGICAL EMERGENCIES. Contact: Janice Alexander, Denver General Hospital, West 8th & Cherokee, Denver 80204. 893-7034. (57 hours of CME credit).

6 FUTURE DEVELOPMENTS IN QUALITY ASSURANCE. Department of Preventive Medicine, University of Colorado Health Sciences Center, Campus Box C245, 4200 E. 9th Ave., Denver 80262. 394-5177.

6-7 SUDDEN INFANT DEATH SYNDROME. Sheraton Inn, Airport, Denver. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver 80218. 861-6949. (AMA Category 1 credit available).

7 NEUROPSYCHIATRIC GRAND ROUNDS. Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

8 CASE PRESENTATIONS AND DISCUSSION OF BARRETT'S ESOPHAGUS. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services, 384-5412.

8-9 WESTERN COLORADO SPRING CLINICS: PUT MORE DOLLARS AND SENSE IN YOUR PRACTICE. Holiday Inn, Grand Junction. Contact: Dr. M. Ray Painter, 243-3061.

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17-22 FINGERS TO THE TOES: AN ORTHOPEDIC APPROACH FOR THE FAMILY PHYSICIAN. Stanford Sierra Lodge. Contact: Ardi Neiswonger, Department of Postgraduate Medicine, School of Medicine, University of California, Davis, CA 95619. (916) 752-0328. (39¼ hours of AMA credit).

U.S. Physician Population Continues Steady Increase

CHICAGO—There were 454,564 physicians in the United States and possessions as of Dec. 31, 1979, the American Medical Association reported.

This is an increase of 17,078 over the previous year.

The physician population data is a part of the annual AMA publication, *Physician Distribution and Medical Licensure in the U.S., 1979*, available this month.

Beer Drinkers Now Assured Freedom From Cancer Fear

CHICAGO—Beer drinkers of the nation can now relax and enjoy moderate amounts of their foamy suds free of at least one health fear—cancer.

The nitrosamine content of both domestic and imported beer is for the most part below the level allowed by the U.S. Food and Drug Administration, says Stephanie C. Crocco, Ph.D., of the American Medical Association's Department of Foods and Nutrition.

The FDA permits only five parts per billion (equivalent to five cents in \$10 million) of nitrosamines in beer. Since January 1, 1980, the FDA has been monitoring the nitrosamine content of both domestic and imported beers. Although an occasional report appears that a given beer contains nitrosamines in excess of the allowed figure, beers usually do not contain such levels, Dr. Crocco reports.

Regulatory and industrial efforts also are aimed at holding down the amount of the substance found in barley malt used in beer production.

Nitrosamines are organic compounds containing nitrogen. Some of them are known to cause cancer in laboratory rats when given at much higher levels.

Of course, the report on beer in the JAMA is related only to nitrosamines and does not discuss health hazards of excessive drinking, including alcoholism and its concurrent health problems, and obesity.

The report is published in the March 6 *Journal of the American Medical Association*.

There were 356,783 physicians in direct patient care on Dec. 31, 1979. Of those in direct patient care, 70 percent pursued an office-based practice (249,585) with the remaining 30 percent in a hospital-based practice, the AMA book reported.

By specialty, physicians in 1979 were concentrated in internal medicine (68,591), general and family practice (58,130), general surgery (33,217), psychiatry (26,860), pediatrics (26,696), and obstetrics-gynecology (25,215).

Thirty-nine percent of all physicians (178,632) were in a primary care specialty.

As of Dec. 31, 1979, there were 96,605 foreign medical graduate physicians in the U.S. and possessions.

The role of women in medicine has expanded and promises to continue to grow in the future. In 1963 only six percent of all physicians were women; by 1979 the figure was 11 percent. There were 50,604 women physicians as of Dec. 31, 1979.

The volume may be ordered from: Order Department (OP 300), American Medical Association, P.O. Box 821, Monroe, Wis. 53566.

Professional Education Up-Date

Aging and Cancer Management. Relatively little attention has been focused on the special problems presented by cancer in old age, despite the fact that approximately 50 percent of all cancers occur in individuals over the age of 65. This two-part article investigates some of these problems and details cancer management in the elderly patient. It also examines current research on the relationship between cancer and aging, since the two phenomena appear to be closely related.

American Cancer Society Factbook for the Medical and Related Professions. This short book introduces the American Cancer Society to the medical profession. Its structure, services, goals and programs are summarized, providing an excellent overview for the new volunteer.

An Approach to the Control of Carcinoma of the Endometrium. A practical approach to the management of the increasingly critical problem of endometrial cancer is discussed by one of the leading specialists in the

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field. Dr. S.B. Gusberg's description of high-risk patients, tips on the identification of precancerous lesions and suggestions for treatment according to stage of disease should be of great interest to any physician called upon to diagnose, refer or treat women with endometrial cancer.

Detection and Diagnosis of Cervical Cancer. Film. This film charts the course of diagnosis in a step-by-step discussion that includes information on the indications for Schiller's test, colposcopy, biopsy, conization and endocervical curettage. The technique of approved pelvic examination is illustrated. Emphasis is placed on detecting cancer of the uterine cervix at an early stage, while the chances of cure are high. Running time, 21 minutes. Color and sound.

Patient Education material is available for your office. For more information on this material, please call: The American Cancer Society, Colorado Division, Inc., 1809 E. 18th Avenue, Denver, Colorado 80218, (303) 321-2464.

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Howard D. Smith, M.D., a native of Salida, Colorado, died on December 8, 1980. Dr. Smith devoted most of his life as a physician and surgeon to practice in Salida. After attending the University of Nebraska Arts College, Smith attended the University of Colorado, receiving his Doctor of Medicine in 1932, and his license in 1934. Dr. Smith served his internship and residency at Denver General Hospital from 1932 until 1935. In 1934, Smith married Frances Ruth Schumacher of Salida. When he returned to Salida in 1935, it was less than a year before he was named the Salida City Physician, a post he held for nearly forty years. He also served as the staff physician of the Colorado State Reformatory for 25 years, until his retirement in 1967. He served in the U.S. Army during World War II, and was discharged with the rank of Captain in 1943. Dr. Smith was a member of the Rotary, the Elks Lodge #808, the International Order of Footprinters, Chaffee County Medical Society, Colorado Medical Society and the American Medical Association.

Stanley J. Haukeness, M.D., of 2004 Crestview Drive, Durango, Colorado, died suddenly on December 14, 1980. Dr. Haukeness, born in Ambrose, North Dakota on April 23, 1925, was educated in the Canada and Montana public schools, then attended Augsburg College and the University of Minnesota Medical School where he received his BA and MD degrees. Dr. Haukeness studied on a residency fellowship at the University of Washington Medical School. He established his practice and his private residence in Durango, Colo-

rado, after marrying Kathleen Joyce Wilson on June 2, 1953. Dr. and Mrs. Haukeness raised a family of four sons and two daughters. Dr. Haukeness served as Chief of Staff of Mercy Hospital and as Secretary of the La Plata Medical Society. He was also a member of the Colorado Medical Society and the American Medical Association.

Harry R. Small, D.O., of 4301 E. Sixth Avenue, Denver, died on February 14, 1981, at Rose Medical Center after a brief illness. Dr. Small was 71. He was born on November 10, 1909, in Mulberry, Tennessee.

After attending the University of North Carolina, Dr. Small graduated from the Chicago School of Osteopathic Medicine in 1940, coming to Denver to establish his practice. He maintained his Denver practice for 40 years and was a staff member of the Rocky Mountain Hospital. He married Rose Sinopoli on June 24, 1962, in Denver. Surviving, in addition to his wife, are a daughter, Rochelle Staffieri of Denver; two brothers, Milton Small of Alexandria, Va., and Phil Small of Fayetteville, Tenn.; and a sister, Carolyn Weaver of Tampa, Fla.

An Alamosa, Colorado, physician, **Dr. Albert Duncan**, was found in his home on March 16, 1981, dead of a gunshot wound. Duncan, a member of the Washington-Yuma County Medical Society and the Colorado Medical Society, was apparently shot by his wife, Juanita, who then took her own life, according to the Alamosa Police Chief, Joe Olson.

The Colorado Medical Society

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Physicians Practice Management Week

| | |
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| Durango | May 5, 1981 |
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Telephone policies and how to develop them
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Cutting down on logjams at front desk
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• **Better Collections, Billing, and Insurance Methods**—1:30 - 5:00 p.m.
(Not recommended for physicians who have attended "Financial Control for Physicians")
COLLECTIONS
Cutting collection costs
Improving your collection percentages
Patient education
Collecting more effectively at the front desk
Establishing a definitive collection policy
Collection techniques that improve your cash flow
How to use the phone to collect
Aged trial balance and its use
Collection agencies and other ways to deal with

delinquent accounts
BILLING
Reducing the number of statements you send
Designing charge tickets that serve as take home statements
Point-of-service collection beats billing
The Super Bill reduces paperwork
Micro-billing saves time and money
Accounts receivable system review and checklist
INSURANCE
How to cut down on insurance processing costs
Physician education
Patient education
Use of standard insurance forms
The Super Bill: reduce insurance billing by 50%
Communicating with insurance companies
The insurance claims log: makes follow-up easy
ACCOUNTS PAYABLE REVIEW
Checkwriting systems
Invoice handling
Petty cash
Refunds
Profitable use of your bank deposits
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• **Financial Control for Physicians**
(Physicians Only)—1:30 - 5:00 p.m.
BETTER FINANCIAL CONTROLS
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Monitoring an accounts receivable control on a daily basis
Reducing your accounts receivable
Better check-signing procedures; how to review your invoices
Controlling petty cash expenditures
Eleven points to better bookkeeping controls
Financial and productivity reporting
Daily, weekly, monthly reports: Examples
BETTER BILLING, COLLECTION AND INSURANCE PROCESSING
How to improve collections, save billing costs and improve your cash flow
Getting patients to pay for office visits when the

service is performed—and reducing your billing costs
Better collections intelligence by "aging" your accounts receivable
Making better use of your charge tickets
The Super Bill—having patients process their own insurance forms for routine office register
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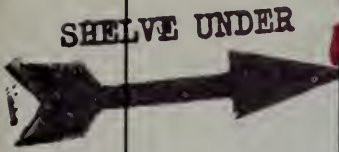
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colorado medicine

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ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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May marked the beginning of a state-wide program to convert the CMS Malpractice Insurance program to a captive, Colorado Physician-owned insurance program. This issue of *Colorado Medicine* has devoted space to the answering of many of the questions which have or have not been asked. You'll find the cover story beginning on page 150.

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Steven R. Lowenstein, M.D., Denver, Colorado

In the past thirty years, health care costs have increased 1500 percent. Dr. Lowenstein, Department of Medicine, University of Colorado Health Sciences Center, says experts in medical education are calling on teaching institutions to recognize their obligation to TEACH COST-CONTAINMENT.

162 Problematic Skin Cancer Treatment by Microscopically Controlled Excision

Patrick J. Lillis, M.D., Loveland, Colorado

Sun-induced basal and squamous cell carcinomas are abnormally high in sunny Colorado, directly related to total lifetime cumulative sun exposure.

166 Critical Care Monitoring

Ernest L. Dunn, M., and Ernest E. Moore, M.D. Denver, Colorado

Past year's monitoring of critically ill in Denver General Hospital has been an accurate physiologic assessment of patient status, and has resulted in improved patient care. The system has encountered no complications after the introduction and utilization of the Swan-Ganz catheter.

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features

136 The Coroner's Lament

Henry W. Toll, M.D., Denver, Colorado

If you are presently using *Cardiac Arrest*, *Respiratory Arrest*, *Cardio-Respiratory Arrest*, *Asystole*, *Ventricular Fibrillation* as cause of death, there may be some injustices. Dr. Toll has some studied alternatives.

147 Drug Therapy: Questions and Answers

Christopher S. Conner, Pharm. D., Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, in association with other Consultation Center professionals.

Fourth in a series of questions and answers about drug therapy.



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The Coroner's Lament— An Open Letter To Clinicians

**CARDIAC ARREST
RESPIRATORY ARREST
CARDIO-RESPIRATORY ARREST
ASYSTOLE
VENTRICULAR FIBRILLATION**

Do you use these terms on death certificates, without giving an underlying cause? Read what follows. You will be saved time, and you will help the families of your former patients and aid the authorities who are concerned with certification of death.

The cause of death classification system in Colorado and the United States is based on the International Classification of Diseases published by the World Health Organization. This classification scheme is based on the concept of underlying cause of death—the disease or condition which initiated the chain of events that lead to death. If you designate non-specific mechanisms of death, such as those above, without giving an underlying cause, you or your office or a hospital record room or perhaps all three will be queried by mail or by telephone for further information. Such a query would not occur if the certificate had been properly prepared to begin with and a cause, rather than a mechanism, of death used.¹

A Coroner's office should not clear certifications without cause of death. After all, "cardio-respiratory arrest" can be caused by manual strangulation or blunt head trauma or gunshot, all of which require further investigation by the Coroner, just as it may also be caused by brain tumor, stroke, coronary occlusion, or other natural causes not in the Coroner's jurisdiction.

I will let the vital statistics people speak for themselves, but it takes little imagination to see that a significant number of certificates signed with these designations makes vital statistics meaningless. In fact, if everyone were to sign all certificates as "cardiac arrest" the apparent death rate from cancer and stroke would drop to zero.

Many doctors say "Cardiac arrest is the only honest certification I can

(Continued on next page)

president's letter

As the Reagan Administration unveils more and more of its definite plans concerning health-care expenditures during the next four years, it becomes ever more apparent that many of the regulatory processes will fall by the wayside because they are specifically killed or are allowed to die an unfunded death. Included in this process will probably be the PSRO activity first mandated by PL 92603. Organized medicine needs to address itself to the issue of what variety of review process will follow on the heels of PSRO, once that program is gone.



We need to address this issue because I think it unrealistic to assume that neither government at any level, purchasers of care at the corporate level, nor individuals organized into groups, will simply allow us to apply "usual, customary and reasonable" standards to the physician charge element of health care cost. We see growing evidence of organization within the government and purchaser groups to begin the process of regulating fees, and usually these regulations address themselves only to cost, and do not address the issue of quality. My own personal feeling is that the physician population is much more interested in quality review, and if care of optimal quality is provided, then that quality of care becomes the standard by which costs, too, should be judged.

I would urge your support of the current efforts of the CFMC in two regards: the first is its quest for continued funding as one of the two opera-

tional PSROs; the second is in the Foundation's efforts to develop other mechanisms for serving both physician and patient needs in the future. This may be through a Colorado-wide review organization, or perhaps through some other vehicle, but we need to continue our support of the CFMC and help direct it, according to the desires of Colorado physicians.

To this end, the Directors of both the CMS and the CFMC have recently approved, in concept, an enhanced communication between those two organizations. This will commence with a more detailed exchange of information at the Board level, will be followed shortly by a joint meeting of those two Boards to discuss common goals and interests, and will produce (at the next meeting of the CMS House of Delegates) a re-created reference committee on Foundation Affairs, which will give physician-members of CMS the chance to comment directly on activities of the Foundation.

From these enhanced communication efforts, I think, will emerge a Foundation more widely supported by Colorado physicians, and more accurately reflective of the needs of Colorado physicians which can be appropriately met by the CFMC.

(Continued from previous page)

make because, without an autopsy, I don't know if the patient had a pulmonary embolus or a coronary occlusion." In fact, if one says "probable coronary occlusion" or "probable coronary embolus," he tells the reader that he is not categorically stating fact but, rather, probability. This is neither dishonesty nor dishonor.

The family of an insured patient

who dies of a pulmonary embolus following a hip fracture may be eternally grateful to you if the patient had a double indemnity policy and the certificate is signed as "pulmonary embolus due to complications of a hip fracture." If "cardiac arrest" were designated as cause of death, the family would receive nothing without an insurance company investigation, a statement from the physician or a court battle.

The physician who puts causes of death on the death certificate makes his life and the lives of those who work with him less complicated. Office personnel, the hospital record room, the hospital nursing service, the Coroner's office, the funeral directors and the vital statisticians will thank you. Though they may not know it, the families of patients may also be indebted to you.

Henry W. Toll, M.D.,
Denver, Colorado

¹Spitz & Fisher, *Medicolegal Investigation of Death*, page 87, Section on Causes, Manner & Mechanism of Death.

Physician Assistance Available

A voluntary advocacy program to help physician members has been developed by the CMS Committee on Physician Health and Rehabilitation. The program is not intended to be punitive, but is designed to assist physicians with impairment to confront individual problems, and treatment. A physician who perceives a problem may seek help, while being spared embarrassment. The House of Delegates-endorsed program has the potential for helping an impaired physician before the physician becomes a danger to self or to patients.

To assist in the program, or if assistance is needed, contact the Physician Health and Rehabilitation Committee by calling the CMS office at 861-1221, or use the WATS line 1-800-332-4150.

Colorado Foundation For Medical Care

In December, 1980, the interim meeting of the American Medical Association voted to "encourage the elimination of all government directed peer-review programs including PSRO." On March 15, 1981, the Colorado Medical Society's House of Delegates at its midwinter session, resolved to support the current Administration's health policy including "elimination of any kind of federal peer-review system including PSRO."

The intent and meaning of the statement "any kind of federal peer-system including PSRO" needs to be clarified; particularly in light of its implications for the continued existence of the Colorado Foundation for Medical Care which is the PSRO for the state of Colorado.

1. What is defined as "any kind of federal peer-review system?" For example, does this mean that peer review for the Department of Defense's OCHAMPUS program falls within this definition? The Foundation currently provides peer review, preauthorization review, develops criteria and standards, and provides medical consultation for the OCHAMPUS program.

2. Does this statement preclude the Foundation from doing peer review for the State Medicaid Agency? As you know, this is a partially federally funded program.

3. How was it determined that the Colorado Foundation for Medical Care's review system is a Federal Review System?

Perhaps there is a need for the definition of the noun "system."

Definition:

1. "Orderly combination or arrange-

ment of parts, elements and so on, into a whole, especially such combination according to some rational principle, any methodical arrangement of parts."

2. "Any group of facts, concepts, and phenomena regarded as constituting a natural whole for purposes of philosophic or scientific investigation or construction."

If you accept this as a definition of a system, and I think you can, then what makes the system we have developed in Colorado a Federal Review System?

1. The Board of the Colorado Foundation for Medical Care establishes policy. It is constituted predominantly by physicians with some representation from other affected disciplines—hospitals, nursing homes, pharmacists. There are no federal employees from federal agencies on the Board.

2. Organizationally, there are five Regional Offices supported by five Regional Councils, composed largely of representatives from local Medical Societies from that region. These Councils deliberate and pass on CFMC Board Agenda items and speak to policy issues that will be addressed by the Board.

Administratively, the staff works with standing committees established by the Board. An example is the Health Care Standards Committee: This committee develops guidelines and criteria by which medical care is evaluated or reviewed. Its composition comes from each of the Medical Specialty Societies. Criteria are developed by subcommittees established to address specific issues. These are brought before the Board for review/adoption or rejection. Again, Regional Councils have the opportunity to review criteria and to make recommendations to the Board.

We submit that this is the physicians of Colorado's system developed to do review. Within the definition of a "system" it is a system developed in Colorado and administered in Colorado. True, the Board has had to address issues, problems, and concerns emanating from the Foundation's contractual or grant relationship with the Health Care Standards Quality Bureau and the Health Care Financing Administration, but then the Foundation will face many of the same problems in doing business with private contractors.

Having defined the noun "system" and having described the elements and parts that make up our system, the question remains, what is defined in the resolution that makes the Foundation, or the PSRO for that matter, a Federal Review System?

Just as the Colorado Foundation for Medical Care's PSRO is a peer-review system which has developed and is directed and controlled by Colorado physicians, every PSRO in the country has developed a peer-review system which reflects the needs and philosophies of its own particular locale. Every PSRO in the country, be it statewide, or limited to a geographic area within a state, has its own physician Board and committees comprised solely of local physicians and health-care providers.

What physicians fail to recognize is that while the federal legislation which put PSROs in place was implemented by regulations which were often burdensome and occasionally counterproductive, PSRO provides physicians with *legislated authority* over utilization and quality of services. With the elimination of that law, physicians will have no guaranteed role in this process. Each third-party payor will have the option of developing its own system; and such systems may be dominated by consumers, business and industry, but not necessarily by physicians. Rather than utilizing one organization to do peer review, each carrier may develop its own peer-review panel and establish its own set of idiosyncratic criteria and standards.

Do the AMA and Colorado Medical Society resolutions mark the beginning of the end of physician control over the appropriateness and quality of medical services?

By Kenneth A. Platt, M.D.

Council on Legislation

The Council on Legislation which has been meeting on a weekly basis since the beginning of the 1981 state legislative session began in early January is now winding down its activities.

The list which follows includes the CMS position and the status (as of May 27) of key bills which were followed by CMS.

| <u>BILL NO.</u> | <u>SUBJECT & SPONSOR</u> | <u>CMS POSITION</u> | <u>STATUS</u> |
|-----------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------|
| SB 80 | SPEED LIMITS (Yost) (There are strong indications that this bill may be incorporated into HB 1590, concerning highways) | Oppose | Postponed Indefinitely |
| SB 113 | NURSE PRACTICE PERMIT- PODIATRIST SUPERVISION (Strickland) | Oppose | Postponed Indefinitely |
| SB 122 | COUNTY CORONERS (Barnhill) | Support | Signed by Gov. |
| SB 179 | REGULATION OF HMO'S (Anderson) | Support w/ Amendment | Awaiting Gov's Signature |
| SB 189 | LIABILITY OF PUBLIC EMPLOYEES (MacManus) | Support | Awaiting Gov's Signature |
| SB 196 | AUTH.-REMOVAL OF CORNEAL TISSUE (P.Sandoval) | Support w/ Amendment | Amended; Awaiting Gov's Signature |
| SB 232 | FEE COLLECT-FACULTY-CU SCIENCE CENTER (Hughes) | Support | Amended; Awaiting Gov's Signature |
| SB 261 | CONCERNING CHIROPRACTIC (Strickland) | Monitor | Amended; Postponed Indefinitely |
| SB 297 | CHIROPRACTIC CARE-WOMEN'S COMP (Hughes) | Oppose | Amended; Awaiting Gov's Signature |
| SB 343 | TEMP. LICENSE-MED SCHOOL FACULTY (Strickland) | Support w/ Amendment | Amended; Awaiting Gov's Signature |
| SB 366 | PEER REVIEW-HLTH INSURANCE CHARGES (Ezzard) | Support | Amended; Postponed Indefinitely |
| SB 468 | IDENTIFYING CODES-PRES. DRUGS (Phelps) | Support | Postponed Indefinitely |

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| | | | |
|---------|-----------------------------------------------------------|-------------------------|--------------------------------------|
| HB 1073 | RAISE MTR. VEHICLE SPEED LIMITS (Stephenson) | Oppose | Postponed Indefinitely |
| HB 1117 | DRUG PARAPHERNALIA (Spelts) | Monitor | Awaiting Senate Action |
| HB 1127 | SEX EDUCATION-PUBLIC SCHOOLS (DeHerrera) | Oppose | Postponed Indefinitely |
| HB 1182 | IMMUNITY-INFORM. DRIVER'S LICENSE (Traylor) | Support | Killed |
| HB 1301 | STATE HEALTH PROGRAM (Neale) | Support | Not Funded |
| HB 1371 | DISPENSING DRUGS (Fine) | Support w/ Amendment | Amended; Awaiting Gov's Signature |
| HB 1405 | CONTROLLED SUBSTANCES (Spelts) | Support | Amended; Awaiting Gov's Signature |
| HB 1408 | SIGHT & HEARING TESTS-CHILDREN (Artist) | Support | Signed by Gov. |
| HB 1437 | DETERMINATION OF DEATH (Strahle) | Support | Signed by Gov. |
| HB 1550 | DEFINITION OF CHILD (Stephenson) | Monitor | Postponed Indefinitely |
| HB 1551 | DEFINITION OF PERSON-RELATING TO HOMICIDE (Stephenson) | Monitor | Postponed Indefinitely |
| HB 1561 | USE OF TITLE OF M.D. BY OSTEOPATHS (Marks) | Oppose | Postponed Indefinitely |

Call for Papers

Grand Canyon International Conference on the Treatment of Addictive Behaviors, Grand Canyon, Arizona, November 17 - 21, 1981

You are invited to submit an abstract of a paper to be considered for inclusion in the afternoon submitted paper sessions at the Grand Canyon International Conference on Treatment of Addictive Behaviors.

Submitted papers should be based on original research relevant to the nature and treatment of addictive behaviors: alcoholism, drug abuse, smoking or overeating. Papers describing relevant treatment outcome research are particularly encouraged.

Abstracts should not exceed 500 words and should reflect the basic methodology and findings of your work. Research in progress may be submitted if informative results will clearly be available by the time of the conference.

Three alternative formats for submitted papers will be considered: (1) paper sessions (2) poster sessions with simultaneous presentation of related papers via poster booths or (3) organized symposia on relevant topics. Specific formats cannot be guaranteed, but stated preferences for particular formats will be honored whenever possible.

ABSTRACTS MUST BE RECEIVED BY July 1, 1981. Abstracts will be reviewed and those submitting papers will be notified of the results by August 1, 1981. All presenters must register for the conference. No fee waiver is provided for presenters of submitted papers.

SUBMIT ABSTRACTS TO:

William R. Miller, Ph.D., Program Chair
Grand Canyon International Conference
Department of Psychology
The University of New Mexico
Albuquerque, New Mexico 87131 USA

AMA Announces Speaker Awards Program for 1981

The fourth national competition for physician-speakers who represent their medical society in various categories has been announced. Following are the ground rules for this competition, which is designed to improve the overall effectiveness of medical spokesmen and to stimulate more consciousness in the Federation for better communication skills in speakers bureaus, meetings and testimony.

In the 1980 competition, Colorado Medical Society and the Clear Creek Valley Medical Society were both winners. COLORADO MEDICINE urges component societies to send a tape of your best speaker for each appropriate category set forth in the rules.

DRUG FRAUD ALERT:

DRUG: Tussionex, Vicodin

A Caucasian male is forging prescriptions on the order form of Dr. William Brubaker, 1001 North Street, Boulder, CO 80302, phone 442-8840. Names used are "James Boyd", "Jeff Levine" and "Mark Hayne". Be suspicious of any prescription from Boulder for narcotics. If you get a Vicodin prescription on Dr. William Brubaker's order form, call the police immediately (Lakewood Police, 234-8511). Tell the dispatcher you have a crime in progress and ask for a patrolman to be sent immediately.

DRUG: Vicodin, Pen Vee K

A Caucasian male, age 31, tall-6'2", thin-170 pounds, is calling in phony Vicodin and Pen Vee K prescriptions under the names Robert Hardy and Robert O'Neill. Subject has been identified as Wesley S. Patterson who has an extensive history of writing phony prescriptions for Percodan and other narcotics. The doctor used is Dr. Eugene Cowen at 761-2813. Please verify any narcotic prescriptions with Dr. Cowen before dispensing.

PHARMACIST HONORED

Betty-Jo Reid, R.Ph. of K-Mart Pharmacy, 7325 W. Colfax Avenue was honored last Thursday by the Sunrise Optimists' Club. Betty received the Optimist's Respect for Law Award for spotting two phony narcotic prescriptions and calling other pharmacists in her area thus alerting them to the fraud. Arrests were made in both cases. Congratulations, Betty, and thanks for a job well done!

ANNOUNCEMENT:

Dr. Frank N. Cochems Competition

The University of Colorado School of Medicine announces the Sixteenth Annual Cochems Competition. A prize of \$2,500 will be awarded to the best paper concerning "Thrombophlebitis and Basic Vascular Problems". It should be concerned with the mechanisms or processes of vascular disease, particularly thrombosis, but not restricted to it. Eligibility is limited to physicians subject to U.S. income tax regulations. Entries must be received in triplicate on or before November 30, 1981. Inquiries regarding the competition and all manuscripts should be submitted to the Dean, School of Medicine, University of Colorado Medical School, 4200 East Ninth Avenue, #C-290, Denver, Colorado 80262.

UNIVERSITY HOSPITAL - Colorado General Among Nation's Top Hospitals: Business Week Magazine

In its April 27, 1981, edition, Business Week Magazine listed the University Hospital - Colorado General as among the best 24 "general care" hospitals in the nation. No other hospitals in the Rocky Mountain Region were included in the listing.

Because of the quality of care and the ability to meet some highly specialized health care needs, the University Hospitals (Colorado General and Colorado Psychiatric) have earned the reputation of being the best in the Rocky Mountain Region and, in some respects, the nation.

The Business Week article, entitled "How to Pick a Good Hospital," stated that an important criterion for such a selection was choosing one of the nation's major teaching hospitals -- one closely connected to a medical school. In the case of the University Hospitals, the affiliation comes through the University of Colorado School of Medicine. The schools of nursing, dentistry and the CU Health Sciences Center division of the university's graduate school also are closely connected to the hospitals.

COLORADO CONSORTIUM FOR CONTINUING MEDICAL EDUCATION

Board of Managers Meeting

March 25, 1981

The main purpose of the Colorado Consortium for Continuing Medical Education Board of Managers was to discuss the future of the Consortium.

In 1978 the Consortium was established as a three-year experimental joint venture to foster continuing medical education (CME) cooperation between the Colorado Medical Society, the Colorado Foundation for Medical Care and the University of Colorado School of Medicine. At this two and one-half year point, the Board met to decide on how best to continue the work of the Consortium, looking at the progress and achievements of the organization to date. Several options were discussed and a decision as to which to pursue will be made at the next meeting of the Board.

Kevin, Bunnell, Executive Director of the Consortium, gave a progress report on projects currently underway.

Accredited CME by Conference Phone

Medical staffs of several Colorado hospitals will be participating in five one-hour presentations via Tele-Net, the long distance conference telephone system developed by Elmer Koneman, M.D. and the Colorado Association for Continuing Medical Laboratory Education (CACMLE). The first two were held on April 17th and May 15th. The last three accredited conferences are scheduled as follows:

Saturday, June 19: "Tumor Board at a Community Hospital"

Presentor: Charles Abernathy, M.D.

Commentator: Samuel L. Jampolis, M.D.,
Presbyterian Medical Center

Origination site: Montrose Memorial Hospital

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Saturday, July 18: "An Old-Fashioned CPC"

Presenter: Department of Pathology,
Penrose Hospitals

Origination site: Penrose Hospitals,
Colorado Springs

Friday, August 21: "Topics in Emergency Medicine"

Presenter: Francis Raley, M.D.

Origination site: St. Mary's Hospital,
Grand Junction

Special features of the Tele-Net system enable physicians to participate directly through a combined microphone and loudspeaker which lets the group talk with the presentors and all other participants. One local person works the conference equipment, reports attendance and handles publicity and other logistics.

Cost to participating hospitals are:

Up to 50 beds -- \$150

51 to 100 beds -- \$200

Over 100 beds -- \$250

The fee covers all participants for all five presentations.

Long-distance line charges average \$25.00 per hour. For hospitals who do not yet have the conference phone, the phone company will install it for a fee of \$15.00 plus \$25.00 per month, rental charge.

If you are interested in, or have questions about any aspect of the Tele-Net conference phone project, please get in touch with Kevin P. Bunnell, Ed.D., Executive Director, Colorado Consortium for Continuing Medical Education, 1601 E. 19th Avenue, Denver, CO, 80218, phone (303) 861-1221 (or outside the Denver metropolitan area dial toll-free 1-800-332-4150).

Physician Placement Services

As a benefit for current and potential members of the Colorado Medical Society, we offer a physician placement service for health care institutions, industry, and other physicians.

CMS uses a computer program which provides timely and accurate "matching" of positions and physicians seeking opportunities in Colorado. This service is a free information clearing house which allows a voluntary assessment by both parties.

It is the Society's goal to offer an effective, ongoing service for its members. The service can also attract new members by providing relevant information which assists the physician and the community in need. There is a minimal charge for non-members of the Society.

One staff member is responsible for developing the placement program. For a copy of the Position Data Form, if you are looking for a placement or you are in need of a physician, please contact the Division of Socio-Economics, at 861-1221, ext.

267. For out-state members, call the WATS line at 1-800-332-4150, during normal business hours.

Clear Creek Valley Member to be Installed as President of Southwest Surgical Conference

Albert J. Kukral, M.D., will be installed in May as President of the Southwest Surgical Congress at a meeting in Monterey, California.

Dr. Kukral received his Degree of Medicine from the University of Illinois in 1944, interned at the University of Illinois Research Hospital in 1945, and served an assistant residency in surgical pathology in St. Louis from 1945 to 1946, with a residency in general surgery at the Veterans Administration Hospital in Salt Lake City, Utah, from 1949 until 1952. Dr. Kukral served a residency in thoracic surgery and was attending thoracic surgeon, both at National Jewish Hospital (1952-1953). He served a preceptorship in thoracic surgery under Dr. John B. Grow from 1953 to 1954. Dr. Kukral was certified by the American Board of thoracic surgery in 1956 and in surgery in 1954.

Dr. Kukral is on the active staff of Children's Hospital, Mercy Hospital, St. Joseph's Hospital, Lutheran Hospital, and he is Chief of Surgery at St. Anthony's Hospital.

Dr. Kukral is currently a member of the American Medical Association, Colorado Medical Society, Clear Creek Valley Medical Society, is a Fellow of the American College of Surgeons, and a member of the Southwestern Surgical Congress.

American Trial Lawyers Can Now Use MEDLINE to Help in Trial Research

MEDLINE (MEDLARS Online) is part of a computerized network providing online access to the Medical Literature Analysis and Retrieval System (MEDLARS) maintained by the U.S. Government's National Library of Medicine. While direct access to this system is normally available only to health care institutions, health professionals and medical libraries, The Exchange has made arrangements with the research section at the National Library of Medicine to provide this service to members of the American Trial Lawyers Association (ATLA).

ATLA Members using MEDLINE will receive bibliographies of relevant medical, scientific, and technical journal articles on a given subject, including complete titles, citations, authors, and in many cases, abstracts.

The data bases in MEDLARS include: MEDLINE, a collection of over two million references to articles from over 3,000 biomedical journals published in the U.S. and 70 foreign countries from 1966 to present; TOXLINE, a collection of over a million references on human and animal toxicity studies, chemicals, and adverse drug reactions; the Registry of Toxic Effects of Chemical Substances; the Toxicology Data Bank; and Cancer Literature (CANCERLIT).

The March, 1981, issue of ATLA's "BAR NEWS" said of MEDLINE: "The comprehensiveness and selectivity of the system produces bibliographies that are extremely efficient ways for trial attorneys to familiarize themselves and their experts with the relevant literature on medical subjects. A national network of 13 Regional Medical Libraries can also provide ATLA members with any item listed in the service."

NOTE: MEDLINE is immediately available to all physician members of CMS through the Denver Medical Library. Just call 861-1221, and ask for the Library. Mary Demund, Martha Burroughs or Vanessa Stephens can explain MEDLINE use to you, and help you with any request.

Alcoholic Women - What Can the Physician Do?

BY

Irene M. Cohen
Alcohol Commitment Coordinator
Alcohol and Drug Abuse Division (ADAD)
Colorado Department of Health

Mrs. J., a 42 year old housewife had been on an uninterrupted, 2 1/2 year drinking binge and was also abusing prescription medication with the alcohol. She was suicidal, physically abusive and diagnosed as having cirrhosis, yet she had never received alcohol treatment. Although she has since been involuntarily committed to a treatment program and has been sober since then, her liver was irreversibly damaged.

Such a case is typical of the calls received by the Division on a daily basis. An increasing number of severely debilitated women are being seen with medical complications related to their drinking histories yet they have had no prior alcohol treatment.

Physicians are often unaware that both emergency and court-ordered alcohol commitment procedures are possible. Early intervention would increase the likelihood of treatment success and someone like Mrs. J. might have avoided terminal damage.

The doctor could urge the family to place a patient who is "intoxicated or incapacitated by alcohol and clearly dangerous to themselves or others" (25-1-310 CRS 1973 as amended) in an ADAD licensed detoxification program on an emergency commitment.

The statute also specifically designates the physician as an appropriate person to apply for an emergency commitment.

If involuntary commitment is sought through the courts, again the statute is clear that a physician may file the petition on behalf of his patient. Another role of the physician could be to support the allegations of family members with a doctor's certificate dated within two days of the filing if the patient has been examined during that period of time.

For further information, please call Irene Cohen (320-6137, ext 370).

Top Health Issues of 1981 - What Are They?

In the editorial business the responsibility of trying to determine what people want to read or hear about is confusing, at best.

For instance: how many issues do physicians want to know about, outside of their own sphere of professional activity; in what detail should those issues be presented, beyond the immediate impact they might have on the doctor's practice? Or, how does the news which concerns the doctor also concern the physician's assistant, the nurse, the nurse-practitioner, the medical aide, the business manager, the secretary, and so on, down the long line.

Editing is an interesting business; it is a continual learning business. Editing is not an occupation with learning the finite detail of each subject or each speciality. It is more of an educated guessing game: the more effective editors are those who have a broader basis on which to make their guesses.

COLORADO MEDICINE editors are attempting to assess the issues as the events occur. Some issues are obvious at the time of their occurrence. Others do not have an immediate impact on the physician community, but should be published, considered, and monitored for their future impact on medicine.

BUT HERE IS THE QUESTION: WHAT ARE THOSE ISSUES? From daily events, from daily comments, from daily happenings in the political arena, we can surmise which are the primary issues of concern to the doctor. That task is not too difficult. The difficulty is in showing the physician what other issues will impact his or her practice, while not seeming to be of an immediate medical nature. For the answers to this question we have to go outside the medical community; we have to ask the lay person; we have to listen to the comments of the patient; we must see what other segments of commerce are doing in relation to costs, prices, inflation, labor, product and service quality control. Any or all of these things will, eventually, affect the practice of medicine.

WHAT TO EXPECT FROM THE '80S

In his recently published BOOK OF PREDICTIONS (William Morrow & Sons, Nov., '80), author David Snyder lays out a fascinating array of futuristic possibilities. Snyder says these predictions are "based on expert forecasts, trend extrapolations and demographic projections. Snyder captures the reader's imagination (and fears) by grading the predictions on a 90% probability (extremely likely to occur), a 75% probability (those events relatively likely to occur), and a 50% probability (events that are as likely to occur as not).

In the 90% category, Snyder says during 1980-82, the annual inflation rate will average between 14 and 16 percent, Congress will deregulate common carrier communications, triggering an overnight socio-technological revolution. He adds that

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"within five years, cable television, electronic mail, and working, studying, and shopping at home will become commonplace."

Snyder predicts that civil servants, teachers, police and fire, transit, and hospital personnel are faced with continued long-term hiring and salary freezes due to poor national economic performance and voter tax revolts. Militant union organization will continue among government employees as well as white collar and salaried professionals.

During 1981-83, Snyder says more than a dozen major U. S. corporations and large American cities are faced with bankruptcy; economic turndown reduces urban revenues--city services are cut back across the board (witness: Denver Health & Hospitals ordered reduction of \$9.4 million in annual operation costs); deteriorating quality of city life substantially slows the urban "renaissance" of the late 1970s.

In 1982-84, Snyder predicts we'll see the cost of petroleum rise to cartel-optimum prices of between \$35 and \$45 per barrel, and energy costs generally double from 1978 to 1980 levels. Information crimes rise sharply; computer fraud will be a common form of grand larceny.

By 1983-85 EFTS (Electronic Funds Transfer System) will be nationwide and the use of cash begins to diminish; the U. S. Supreme Court overturns state and federal privacy protection statutes.

Looking to 1984-86, Snyder says the trend toward a "sensate" society continues, with the legalization of Marijuana, under regulation, and some hallucinogens are licensed for recreational purposes.

During the 1985-87 time warp, Snyder predicts that at least one-half of all U. S. households will be connected to an interactive video/data communications network, permitting shopping and working from the home, and two-way discussions with instructors of televised classes, with political candidates, and with public officials.

David Snyder's Book of Predictions is fascinating, provided the reading doesn't frighten you away from finishing the book. I haven't dealt with any predictions beyond those in the 90% probability; that isn't necessary to this column. Just look at those developments (which most of us will concede) are on the horizon within the next six years. How are those developments that I have mentioned here going to affect your medical practice? Each of them, and the many other unmentioned or unforeseen, will have some kind of impact on your professional life in medicine. What I have suggested here merely deals with the broad prognostication. What about the very real fragmentation that is occurring, or that we know will occur in all of our lives? Which brings us back to NOW:

At the beginning of 1981 I had a conversation with Martha Eastman of the Visiting Nurses Association of Denver. Martha wanted to know what

the Colorado Medical Society thought were the top five health issues of the year. I said I would like to know, also. If that question were one of strictly physician interest it would have been easy to give a reply. Instead of approaching the question from strictly the physician point of view for our magazine, I did a mini-survey of non-physicians: some people who are involved in the medical and health care industry, others who are not (pure health care consumers). Here's what I found to be on the minds of the majority of our interviewees, ranked in order of importance to the individual:

TOP FIVE HEALTH ISSUES, IN WHAT ORDER, AND WHY:
(any issue which impacts on community health)

1. Cost of health care and medical treatment.
2. Changing of life styles (necessity of people changing the way they live in order to protect their health, such as the use of alcohol, tobacco, drugs, etc.)
3. Finding cures to leading causes of illness and death (heart disease, cancer, etc.).
4. Availability of care.
5. Health environment (how healthy is our environment, in terms of pollution, carcinogens, etc.).

Now, it is your turn: you, the physician, the medical assistant, the nurse, etc., should address your health and medical concerns to me, so that I can print them in this magazine to alert others in your profession and allied industry. I am not going to survey you in a formal manner. I am going to invite you to make your voice heard, for your own and other's benefit.

What are the top public health concerns of this day, in your eyes? How will they impact the general public and your own profession? I would like to print these responses in the July, 1981, issue of COLORADO MEDICINE magazine. I want to supply your comments to the profession, the society and to the public. Has anyone asked you lately your opinion on these subjects? Probably not, because they thought your answer would be solely on the basis of protecting your own pocketbook. COLORADO MEDICINE asked the non-physician first. Now it's your turn. We have just stated what their concerns were; we want to know your concerns.

As an editor, I have a tough job guessing what it is you want and need to know. Believe me when I say it is all an educated guess. There are many other factors involved in making a good guess: empathy, a minimum of professional understanding, a maximum of business and social acumen, a desire to perform the editorial task as required by the reader.

Educate me!

Bill Pierson,
Director of Communications
Colorado Medical Society

Ethics Policies for Doctors Stated in New AMA Publication

CHICAGO—Quality of life, allocation of health resources, illegal or excessive fees, confidentiality and informed consent are just part of the issues thoughtfully deliberated by the American Medical Association's Judicial Council in its new publication, *Current Opinions of the Judicial Council of the American Medical Association*, 1981.

Current Opinions relates to the revised Principles of Medical Ethics adopted by the AMA House of Delegates in 1980. *Current Opinions* "are not presented as the sole or only route to medical morality," according to the Judicial Council. *Current Opinions* supercedes all earlier publications of the Judicial Council.

Limited health care resources should be allocated efficiently and on the basis of fair, acceptable and humanitarian criteria, the Council states. Priority should be given to persons who are most likely to be treated successfully or have long term benefit. Social worth is not an appropriate criterion.

The AMA declares positively that "A physician should not charge or collect an illegal or excessive fee. For example, an illegal fee occurs when a physician accepts an assignment as full payment for services rendered to a medicare patient and then bills the patient for an additional amount."

The Council states that informed consent is vital to the physician-patient relationship.

"The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his own determination on treatment. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

In caring for defective infants, the Council declares, the advice and judgment of the physician should be readily available, but the decision whether to treat a severely defective infant and exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks

and limits of any proposed care; how the potential for human relationships is affected by the infant's condition, and relevant information and answers to their questions.

In coping with terminal illness, the Council says, the social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict.

The booklet may be purchased from: Order Department OP-122, American Medical Association, P.O. Box 821, Monroe, Wis. 53566. Single copies are \$4.00.

Weight Reduction Programs Record Few Successes and Many Failures

CHICAGO—Too fat? You have a lot of company. Much of the nation is too fat.

And the extra fat largely defies the best efforts of medical and behavioral sciences to take it off.

Noting the many who start diets only to drop out, plus the many more who lose pounds only to put them right back on again, Harvard Medical School Expert Bruce R. Bistrian, M.D., concluded:

"We still do not have a medical treatment of obesity that is permanently effective for the majority of out-patients."

Writing in an American Medical Association publication, *Archives of Internal Medicine*, March, 1981, Dr. Bistrian recaps the results obtained by physician-directed weight loss programs, by non-profit, self-help efforts such as Weight Watchers, and by the commercial weight reduction plans. The percentage of lasting success of all three is quite low.

This doesn't mean we should quit trying. For a minority of dieters, each of these approaches works. Some do lose weight, and keep it off.

"One cannot dispute the potential value of such programs, as long as unrealizable expectations are not encouraged," Dr. Bistrian says.

Common Disorder

Obesity is one of the most common disorders in industrialized society, he

declares. Thirty-two percent of American men and 40 percent of American women between the ages of 40 and 49 years are at least 20 percent above ideal body weight.

For more than 100 years the degree of overweight has been increasing in the United States, without any recent signs of abating. Americans are getting steadily fatter with each generation.

"There is little question that obesity is an important risk factor for premature mortality and that correction of overweight is probably the most important hygienic measure (aside from avoidance of cigarettes) available for the control of cardiovascular disease."

If the fat person does not also have high blood pressure, high cholesterol or diabetes, the extra weight becomes a health problem at about 30 percent over ideal weight for height and sex, the Boston physician says.

"Excess body weight below 130 percent of ideal should probably be considered a normal variant and primarily of cosmetic or psychological importance."

Most individuals drop out of weight reduction programs within a few weeks, others within a few months. Those who do remain in the program often have only modest weight loss. And short-term weight loss, even of a major degree, does not guarantee nor even make likely long-term weight maintenance, Dr. Bistrian says.

Maintenance Very Difficult

Taking it off and keeping it off are separate components, he adds. Weight maintenance once the desired size is reached is far more difficult than weight reduction. Behavior modification techniques show some promise for this purpose, he says.

In the same issue of the *Archives*, Fred R. Volkmar, M.D., of Stanford University Medical Center, Palo Alto, and colleagues report on a new study of the success ratio of commercial weight reduction programs.

In a study of 108 women enrolled in a commercial weight reduction program, Dr. Volkmar found very high attrition rates; 50 percent dropped out in six weeks and 70 percent in 12 weeks. Similar attrition rates are cited

in five other programs in three different countries.

Some one million people each week are participating in group efforts at weight reduction without medical direction, Dr. Volkmar says. Persons joining some of the groups had previously joined and dropped out an average of three times.

Dr. Volkmar also stresses that the programs are not entirely useless. The high attrition rate obscures the importance of weight losses of subjects who remained in the program, he says. Unfortunately, evidence is lacking as to how well these latter individuals succeed in keeping their weight down, permanently.

For those individuals afflicted with "morbid obesity," the need to lose weight is greatly increased. There are some three million Americans at least 40 percent above ideal body weight, says Ward O. Griffen, Jr., M.D., of the University of Kentucky Medical Center, Lexington.

Morbid obesity is associated with all sorts of life-threatening disorders. And, unfortunately, approaches to weight control, including dieting, diet pills, rational behavior therapy, and psychotherapy, have not been successful in bringing lasting weight reduction, Dr. Griffen says.

Bypass Surgery

One technique, used only in grossly overweight individuals, is surgery. Ninety percent of the intestine is bypassed, sharply reducing the amount of food absorbed by the body. But this approach has caused so many unpleasant side effects that it is now used only in extreme cases. It brings excess diarrhea, imbalance of body fluids, kidney dysfunction, liver abnormalities. But it does bring great weight loss.

Recently another surgical approach has been utilized, gastric bypass, in which a major part of the stomach is stapled off, curtailing sharply the amount of food that can be eaten at one sitting.

Dr. Griffen reports on experience with converting the intestinal bypass to the stomach bypass in 32 individuals. The conversion operation was successful. Weight reduction was maintained without the many unpleasant side effects of the intestinal bypass, he says.

Dr. Griffen's report appears in

another AMA publication, *Archives of Surgery* (March, 1981).

Nuclear Emergency Evacuation Plan For Hospital Patients Prepared

CHICAGO—Areas surrounding nuclear power facilities must recognize the possible extent of a nuclear incident and plan for evacuation of up to 20 miles around, declares a report in the April 24 *Journal of the American Medical Association*.

The lessons learned during the Three Mile Island episode in Pennsylvania in the spring of 1979 with regard to evacuating patients in hospitals and nursing homes are reported by J. Stanley Smith, Jr., M.D., of the medical command team in Dauphin County, Pa., and James H. Fisher, the county's medical coordinator.

Three major problems were encountered by the medical leaders in the area in preparing to evacuate some 3,700 patients in hospitals and nursing homes within the risk zone, Dr. Smith, of the Harrisburg, Pa., Polyclinic Medical Center, says.

These problems were: 1) Communications; 2) Transportation; 3) Manpower.

Communications and reliable information were scarce regarding the status of the nuclear incident and the probability of activating plans to evacuate the hospitals and nursing homes, Dr. Smith reports. The medical leaders depended heavily on network radio and TV reports for news, he says. There was no constant flow of information to the Dauphin County Office of Emergency Preparedness (formerly Civil Defense), Dr. Smith relates.

Finding and enlisting available medical transport vehicles in the area was a major problem, and "We were never sure whether we would get what we needed when we needed it. Furthermore, we estimated that it would take approximately 36 hours to accomplish evacuation of all medical facilities, not the four to eight hours continually quoted by the governor's office."

As word spread of the possible nuclear accident, many individuals began to leave the area. This exodus included medical care personnel, as well as the general public, and staffing of the hospitals and nursing homes

became an acute problem, Dr. Smith reports. Hospitals discharged all patients able to leave, accepted only emergency cases, and postponed elective surgery and diagnostic tests. By reducing the patient census by more than 50 percent, the hospitals kept going with the reduced staffs.

The alert lasted for a full week, until it was determined that the emergency was over. People began returning to their homes and a normal pattern gradually was resumed.

In response to the nuclear incident at Three Mile Island, The Dauphin County Office of Emergency Preparedness has prepared a plan outlining nuclear incident emergency medical procedures, Dr. Smith reports.

Copies of the Nuclear Incident Emergency Medical Plan Outline are available on request to the Emergency Health Services Federation of South Central Pennsylvania, 3514 A Trindle Road, Camp Hill, Pa. 17011. A contribution of \$10 is requested to defray expenses for each copy.

Drug Fraud Alert

DRUG—Dilaudid and Empirin with Codeine

Two forged prescriptions have been reported involving a man described as a Caucasian male, age 59, 5'9", weight-thin, stooped shoulders, dark hair, usually wears old, dirty, oily clothes, possibly a service station uniform. The first prescription was for Dilaudid on F. Dean Barta, DDS, order forms. The second was for Empirin with Codeine on Charles H. Lapan, M.D., order forms. Dr. Lapan is now retired.

DRUG—Percodan

Suspect is a Caucasian male, age 24, 6'0", 220 lbs. (stocky), blond hair, blue eyes, moustache. Arrested once in Golden for forging Preludin on Dr. E. Dean Bray's order forms. Active again for Percodan on Swedish Medical Center order forms, same Dr. E. Dean Bray. Suspect, using various names, is really Roderick R. Virtue. He is currently wanted by police. Incidentally, Dr. Bray moved to Saudi-Arabia on April 20, 1981.

Drug Therapy: Questions and Answers

Christopher S. Conner, Pharm.D., Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; Dennis R. Sawyer, Pharm.D., Associate Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; and Earl Sutherland, M.D. Ph.D., Medical Director, Rocky Mountain Drug Consultation Center, Attending Physician, Assistant Professor of Medicine, University of Colorado School of Medicine.

This bimonthly column is designed to provide Colorado physicians with specific answers to commonly asked questions regarding drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column were generated from calls received by the Rocky Mountain Drug Consultation Center from Physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver metro area or 1-800-332-6475 in Colorado for specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure, and drug identification. The Center is available from 8:00 A.M.-8:00 P.M. Monday through Friday, with 24 hour on-call service.

CAFFEINE WITHDRAWAL

Request:

A middle-aged housewife is current-

ly consuming 25 or more cups of brewed coffee daily. Other medications are theophylline, ephedrine, and a thiazide diuretic. What withdrawal symptoms can be expected upon cessation of all caffeine sources in this woman? What is the usual management of caffeine withdrawal?

Response:

A cup of brewed coffee contains approximately 100 mg caffeine. Physical dependence to caffeine has been demonstrated with the long-term consumption of as little as five cups of coffee per day (Goldstein, et al, 1969). The regular consumption of 500-600 mg of caffeine daily, and subsequent abrupt cessation of the drug, reliably results in a caffeine-withdrawal syndrome, featuring intense headache as the most prominent symptom. These headaches have been clinically observed (Greden, 1974), experimentally induced (Driesbach & Pfeiffer, 1943), and documented to occur in natural settings (Goldstein, et al, 1969).

Typically, symptoms begin between 12 and 18 hours after the last caffeine ingestion. This correlates well with the half-life of caffeine in humans, 3.5 hours. A feeling of "cerebral fullness" ensues, which quickly becomes a diffuse, throbbing headache, peaking 3-6 hours after onset and lasting up to 36 hours (Greden, et al, 1980).

A 32 year old housewife who had consumed over 500 mg of caffeine daily for 20 years described withdrawal headaches beginning behind the eyes and back of the head. Within 3 hours the headache became a generalized "splitting headache", which was exacerbated by exercise, bending the head, or exposure to bright

lights. Headache symptoms completely disappeared within 90 minutes of rapid consumption of 300 mg of caffeine (Greden, et al, 1980).

In a questionnaire given to 152 hospitalized patients, 28 percent reported having experienced caffeine-withdrawal headaches. The mean intake of caffeine for the headache group was 616 mg/day compared to 394 mg/day in the non-headache group. The headache group scored significantly higher on the State-Trait Anxiety Index and Beck Depression Score, consumed more antianxiety agents, felt they were generally less healthy and were less active in religion than the non-headache group (Greden, 1980).

A number of other withdrawal symptoms have been noted, including yawning, lethargy, rhinorrhea, irritability, dysphoria and nausea (Goldstein, et al, 1969).

Management of caffeine withdrawals is usually a "cold turkey" approach, since even slight reductions in the usual caffeine intake have produced headaches. Patients are usually symptomless within 48 hours (Josephson & Stine, 1976). Supportive measures include patient education, restriction of coffee drinking to certain times during the day, and substitution of decaffeinated coffee. Occasionally, temporary use of caffeine-containing analgesics is needed.

References:

- Driesbach, R., Pfeiffer C., "Caffeine Withdrawal Headache." *J Lab Clin Med* 1943;28:1212-18.
Goldstein, A., Kaizer, S., Whitby, O. "Psychotroic Effects of Caffeine in Man. IV. Quantitative differences Associated with Habituation to Coffee." *Clin Pharmacol Ther* 1969; 10:489-97.

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- Greden, J. "Anxiety or Caffeinism: A Diagnostic Dilemma." *Am J Psychiatry* 1974;131:1089-92.
- Greden, J., Victor B., Fontaine, P., Lubetsky, M. "Caffeine-Withdrawal Headache: A Clinical Profile." *Psychosomatics* 1980;21:411-18.
- Josephson, G., Stine, R. "Caffeine Intoxication: A Case of Paroxysmal Atrial Tachycardia." *J Am Coll Emerg Physicians (Ann Emerg Med)* 1976; 5:776-78.

PHENOTHIAZINE WITHDRAWAL

Request:

What effects can be expected in phenothiazine withdrawal? What is a good withdrawal regimen for phenothiazines?

Response:

Abrupt cessation of phenothiazine therapy may result in both withdrawal effects and psychotic exacerbation. Withdrawal symptoms occasionally seen within a few days of abrupt phenothiazine withdrawal include nausea, vomiting, headaches, tremors, sweating, tachycardia, malaise, and insomnia (Klein & Davis, 1969). Brooks (1959) reported symptoms of abrupt withdrawal of phenothiazines in 28 chronic schizophrenics. Onset of withdrawal symptoms occurred in 2-4 days and consisted of tension, restlessness, insomnia, perspiration, and vomiting. The duration of withdrawal symptoms was reported by Judah, et al, (1961). Withdrawal of ataraxics in 500 chronic schizophrenics produced common withdrawal symptoms, but most of these disappeared within 1 or 2 weeks following discontinuation of the drug. Relapses of psychotic symptomatology upon withdrawal are common and frequently result in re-hospitalization. Relapses often do not occur until 3-6 months after a decrease or discontinuation of the medication (Klein & Davis, 1969).

These effects of withdrawal may occur even with low doses of phenothiazines and to avoid them, it is best to lower the dosage gradually. Several methods of antipsychotic withdrawal have appeared in the literature, but it appears there is no general consensus as to the best method. Klein and Davis (1969) recommend lowering the

dosage by 10 to 25 percent a day, moving more slowly with higher daily doses. Our experience, however, has shown that this may be too aggressive a regimen, especially in patients on long-term, high dose therapy. In patients on long-term therapy, reductions of 10-25 percent every two weeks is probably more appropriate. This method is based on the assumption that it takes about two weeks to achieve a new steady state serum level following dosage reduction. Clinical effects of a particular dosage reduction should be evaluated before another dose reduction is instituted.

References:

- Brooks, G.W. "Withdrawal from Neuroleptic Drugs." *Am J Psychiatry* 1959;115:931-2.
- Judah, L.N. et al. "Results of Simultaneous Abrupt Withdrawal of Ataraxics in 500 Chronic Psychotic Patients." *Am J Psychiatry* 1961;118: 156-8.
- Klein, D.F., Davis, J.M. *Diagnosis and Treatment of Psychiatric Disorders*. Williams and Wilkins Co., Baltimore, 1969, pp. 27, 67-9.

KANAMYCIN IRRIGATION AND RESPIRATORY PARALYSIS

Request:

How common is muscle paralysis and respiratory arrest following kanamycin irrigation in surgical patients also receiving skeletal muscle relaxants?

Response:

Three cases of paralysis and apnea following intraperitoneal irrigation with kanamycin solution appear in the literature (Mullet & Keats, 1961; Noble, 1976; Eppens & Kleins, 1971). Mullet and Keats (1961) reported flaccid paralysis and apnea following instillation of approximately 75 mg of kanamycin in a 3 day old (3.25kg) female infant who had received succinylcholine 15 mg IM as an adjunct to the anesthesia. Assuming a volume of distribution of .4 L/kg, 62.5 mcg/ml is a possible peak serum level from the 75 mg dose. Noble (1967) reported a case of respiratory insufficiency in a 47 year old female following kanamycin 500 mg IM pre-op and intraperitoneal lavage with kanamycin 1 gm in

200 ml saline before closure. Gallamine 190 mg was given as anesthesia adjunct. A kanamycin serum level of 50 mcg/ml was measured approximately 1 hour after respiratory insufficiency developed.

Following kanamycin lavage (1 gm in 200 ml of normal saline), peak serum levels occurred between 15 and 75 minutes in 17 adults undergoing abdominal surgery (Ericsson, et al, 1978). An average peak concentration of 20.3 mcg/ml followed 5 minutes of lavage and 15.3 mcg/ml followed a 2 minute lavage. An average of 60 percent of solution was recovered by suction. No effects on muscle tone or respiration were detected in these 17 patients.

Conclusion:

Paralysis leading to respiratory insufficiency has been reported following intraperitoneal lavage with kanamycin, however, the reactions were associated with high serum levels. If kanamycin lavage is to be used, pre-op IV or IM therapy should be avoided, the total amount of kanamycin in the lavage solution should not exceed 1 gm, and the duration of lavage should be short since lavage for two minutes produces high therapeutic serum levels. If the solution is not to be removed before closure of the abdomen, the total amount of kanamycin should not exceed the recommended systemic dose, adjusted for the patient's renal function.

References:

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- Ericsson, C.S., Duke, J.H., Pickering, L.K. "Clinical Pharmacology of Intravenous and Intraperitoneal Aminoglycoside Antibiotics in the Prevention of Wound Infections." *Ann Surg* 1978;88:66-70.
- Mullett, R., Keats, A.S. "Apnea and Respiratory Insufficiency after Intraperitoneal Administration of Kanamycin." *Surgery* 1961; 49: 530-33.
- Noble, R.C. "Respiratory Insufficiency After Intraperitoneal Administration of Kanamycin: Failure of Calcium Gluconate to Reverse Toxic Effects." *Southern Med J* 1976;69(9): 1218-19.

Lobbying is done from both an offensive and a defensive stance whether that position is on a bill or on an amendment. And we have had ample opportunity to do both kinds of lobbying in this legislative session. It is easier to kill a bill than to pass one in exactly the form in which you want it. Someone has compared introducing a bill and sheparding it through the legislature with putting a message in a bottle and tossing it into the ocean. One can only hope that the bottle reaches its hoped-for destination with the message intact and unaltered.

HB 1301, the medically indigent insurance bill, is a perfect example of a bill on which we are on the offensive but must constantly have our defensive unit ready when amending is done. Compromise is necessary if the bill is to have a chance of passage, but compromise can go only so far without selling out physicians. There are also many bills not in any way introduced by CMS but which our offense must attach amendments. These include bills concerning HMO's, the pharmacy practice act, controlled substances, certificate of need, hereditary disorders, and a host of others.

A number of bills have died, many with our help or at least our lack of support. This seems to be a good time to list those dead bills and follow up next month with bills that have successfully wended their way through the legislative process.

Dead Bills:

SB 91: Registration of Athletic Trainers. Dodge: Would have created the state board of registration of athletic trainers which would be charged with the duties of registering athletic trainers.

SB 113: Permitting Nurses To Practice Under the Direction and Supervision of Podiatrists: Amended the nurse practice act to ensure that nurses could practice under the direction and supervision of podiatrists as well as physicians and dentists.

SB 207: Regulation of Nonphysician Health Care Providers: Authorized nonphysician health care providers to do limited medical treatment function when working under the supervision and control of a licensed practicing physician. Those health care providers would have been certified by the Board of Medical Examiners.

SB236: Inclusion of Chiropractic and Podiatric Care Under the Provisions of the "Colorado Health Maintenance Organization Act": Included chiropractic and podiatric care with the definition of "Health care services". Also included podiatrists in the definition of "provider".

SB 306: Community Mental Health Services and Providing for the Purchase Thereof: Provided for the purchase of community mental health services through community mental health centers and established standards for approval.

SB 347: Concerning Authorization for Governing Bodies of Political Subdivisions of This State to Participate in the Designation of Mental Health Service Areas: Authorized governing bodies of political subdivisions of the state to designate catchment of mental health service areas for the delivery of mental health services through the community mental health centers.

SB 423: Certificates of Public Necessity: Amended provisions as to when a certificate of public necessity is required. Authorized the appropri-

ate health systems agency to make final decisions on specified clinical and nonsubstantive nonclinical services projects.

SB 468: Identifying Codes for Prescription Drugs: Required all prescription drugs to be imprinted with a unique symbol or other marking. *Comment:* The committee felt that it made much more sense to legislate this at a federal level.

HB 1182: Immunity from Suit for Providing Information Concerning Driver's Unfitness: Granted immunity from suit to medical advisory board members and others for providing information to the department of revenue concerning a driver's mental or physical impairment which could cause the driver to lose his license. *Comment:* A committee made up primarily of lawyers couldn't accept the breaking-down of physician-patient privileged communication.

HB 1550: Definition of Child in the "Children's Code": Amended the definition of "child", as used in the children's code to specify that the term applied from the time of conception.

HB 1551: Definition of Person as Used in Statutes Relating to Homicide: Amended the definition of "person" as used in provisions concerning homicides and related offenses, to include a living fetus.

HB 1561: Authorizing the Use of the Title of Medical Doctor by Qualified Osteopaths: Provided that the state board of medical examiners could authorize the use of the title of medical doctor by osteopathic doctors, if certain qualifications were met.

Educational Conferences

First Intermountain Conference on Continuing Medical Education—April 17, 1981, in Salt Lake City, Utah.

Planners, presenters and attenders of Colorado CME programs may register for the Academy for Continuing Medical Education. The theme of the conference will be "Practical Approaches to CME", supported by a faculty of national, regional and local CME specialists. The program is certified by the University of Utah College of Medicine for 7 hours of Category 1 CME credit. *Registration is limited to 100 people.* If you are interested in attending, call or write immediately to Dale Breadon, Director, Utah Academy for CME, 540 East Fifth South, Salt Lake City, UT 84102, (801) 355-5290.

Highlights of the Meeting of the Board of Managers of the Colorado Consortium for Continuing Medical Education, March 25, 1981.

The main purpose of this meeting of the Colorado Consortium for Continuing Medical Education Board of Managers was to discuss the future of the Consortium.

In 1978 the Consortium was established as a 3-year experimental joint venture to foster continuing medical education (CME) cooperation between the Colorado Medical Society, the Colorado Foundation for Medical Care and the University of Colorado School of Medicine. At this 2½ year point, the Board met to decide on how best to continue the work of the Consortium, looking at the progress and achievements of the organization to date. Several options were discussed and a decision as to which to pursue will be made at the next meeting of the Board.

Kevin Bunnell, Executive Director

Denver's Mayor is prepared to cut back the services of the Denver Department of Health and Hospitals and Denver General Hospital. That, basically, is what Denver Mayor William McNichols told a recent meeting of the Denver Medical Society Task Force on Public General Hospitals.

Mayor McNichols, with Assistant to the Mayor, David Foote, and Dick Brown, lobbyist for the City and County of Denver, joined the new Manager of the Denver Department of Health and Hospitals, J. L. Kurowski, M.D., to insist that the moment of truth has arrived and a reduction in the budget of the Department is imminent.

Mayor McNichols said he would rely on Dr. Kurowski and medical experts for advice as to the best method of performing this "surgery."

The problem faced by the Depart-

of the Consortium, gave a progress report on projects currently under way.

New National Accrediting Body Now in Operation

The Accreditation Council for Continuing Medical Education (ACCME), the new single, national accrediting body, is officially in operation. All AMA accreditation files have been transferred to ACCME office headquarters in Lake Bluff, Illinois, where they will be consolidated with LC-CME files. ACCME staff will continue to work on revising the *Essentials for the Accreditation of Sponsors of Continuing Medical Education*. The "Essentials" are probably three to six months from completion because of normal start-up time needed by the new council.

ment has been a major concern of the city administration for six or seven years, the Mayor said. In 1974, the city, for the first time, asked for state dollars for reimbursement of care for the medically indigent because of increasing usage by the non-Denver residents. From that time to the present there has been an annual request for state reimbursement. It has provided about 40 cents on the dollar from the Legislature. However, legislators have refused to understand the difficulty of tracking this very mobile population and pin-pointing where they come from. It is obvious that the absence of facilities to care for them elsewhere in the state, with the exception of the University Hospital, means this population gravitates toward Denver and Denver General Hospital.

The Mayor explained the Department has three defined functions of equal priority: emergency medical services, care of the medically indigent, and general public health functions. In the present crisis, he feels the Department will have to start with a premise of maintaining emergency medical services, and after that, determining what other programs can be sustained.

Dick Brown indicated that a concerted effort is continuing to persuade the Legislature of the need to develop both long and short-term solutions for the funding of care for the medically indigent.

David Foote is preparing a formal position statement for the city dealing with these issues to be released soon.

Dr. Kurowski emphasized the need for coordination of public services with the private sector, including both doctors and hospitals, particularly if the Department is forced to cut back some of its services.

Tools For Patient Communication

Editor's note: This article assumes the position of a patient in your office, with comments from the patient's perspective. The article is designed to be of help to you, to serve as a reminder as to the (possible) missing facet of your patient relations. The patient will remain anonymous, and the article speaks to no certain physician, but to ALL physicians.

A physician's responsibility to the patient includes perceiving the patient as a unique individual. When I don't understand the doctor or the doctor misunderstands me, a problem occurs. This could result in my seeking another physician. It may also cause me to become dishonest with you, doctor.

I believe that you, as a physician, must be aware of my attitude. You have to try to realize when 1) I'm afraid you might find something wrong with me; 2) I won't go to the hospital; 3) you scare me; 4) I don't like to take medicine; 5) I think doctors do make mistakes; 6) I had to sit in that waiting room over an hour to see you; 7) your fees are too high; 8) I admit that you are smart, and; 9) I want you to like ME.

I admit, not every patient is like this, but there are many who are, and the doctor should be aware of certain strategies to assist in building the communication flow. First, be aware of the patient's non-verbal behavior. I can't describe it very well, but I know that I use this type of communication, probably unconsciously, to tell you how I feel about myself . . . or about you. What does non-verbal behavior consist of? It may include posture, gestures, facial expressions, costume or dress, the way I walk, even the treatment or regard of time and space. If you are not aware that I am telling you something, even with my physical gestures, then you are not getting all of my messages.

I think you, the doctor, should be very aware of your own non-verbal communication. For example, if you frown while you're with me in the examining room, it is very easy for me to think "there is something horribly wrong with me." Oh yes! The lack of congruity between spoken words and behavior can make me mighty anxious and uncomfortable, too. Few

people realize how much we all depend on the hidden rules of listening behavior; however, we know instantly whether the person we are talking to is "tuned in" or not. It's true: I can become very sensitive when I feel that breach in your listening etiquette.

I like it very much when you appear to be honestly listening to me. I don't like it when you sit down at your desk and start writing on the chart or scribbling out a prescription while I'm trying to explain my feelings or my aches and pains. Granted, you have a very full schedule, and you are in a hurry to treat all those people who have been sitting in your waiting room for so long. That doesn't change my case. I like it when you appear genuinely interested, nod your head in understanding, and keep eye contact with me when you are involved in this communication. I know, you've heard all these symptoms over and over, but I am the one who is presently concerned and trying to communicate with you.

It is important for you to remember that each person has a natural sense of personal space. A person's comfort may vary with regard to their physical distance from another person . . . even their doctor. In communicating with your patient it is important to keep that proper distance in mind, and the distance which is called for by the situation. I know, it is difficult. The doctor often needs to "invade" a person's space (to listen to his heart, for instance); therefore, the doctor should be aware of the tension and uneasiness this may arouse in the patient. One reaction to this type of invasion, and you may have noticed this, is that the person avoids eye contact with you. If you see that your pati-

ent is not looking at you, you may be too close for his comfort.

I realize it is impossible for you to know and become aware of every nonverbal signal, but as long as the power of these signals is understood, an improved practice relationship will result. Remember: I said I like you, and I don't want to go shopping for another doctor, and have to start all over training him how I react and how I want to be treated, mentally, emotionally, as well as physically. I need to have confidence in you, so I want to help you work on this relationship.

Of course, I don't want to get sick, but if I do I'll feel better very quickly if I know you're listening. Thanks, doctor.

Cost Efficient Medical Practice and Industrial Committees Formed

The Council on Socio-Economics has established two new committees to assist organized medicine in the shift toward a "competitive mode".

The Cost Efficient Medical Practice Committee will meet with the Insurance Commissioner of the State of Colorado in an attempt to develop a study of the make-up of the Denver Consumer Price Index.

An Industrial Liaison Committee will soon be appointed to relate to a coalition of industry and labor which will negotiate payments to hospitals.

If you are interested in serving on or commenting to either of these Committees, contact K. Mason Howard, M.D., President, Colorado Medical Society, 1601 E. 19th Avenue, Denver, CO 80218.

Colorado Medical Society Launches 1981-1982 Professional Liability Insurance Program

Executive Committee- CMS Asks the Hartford For New Package

Colorado Medical Society Executive Committee members have completed a long-term negotiations program with The Hartford Insurance company regarding a renewal package to be endorsed by CMS membership.

The Hartford was asked to share with CMS the excess limits coverage profits in a new contract. Hartford's answer: "NO".

The Hartford was asked to increase the share of basic limits profits with CMS. Hartford's answer: "YES", (conditional on the exact percentage of increase).

The Hartford was asked to reduce the percentage of each premium dollar collected which goes directly to expense reserves, and the answer was "NO".

Current administrative expenses and unallocated claims dollars take 8.7% of every premium dollar.

The Hartford was asked to reduce its profit and contingency percentage, which is 7.5%, and which comes off the top of every premium dollar before any administration or policy business is ever done. The Hartford said "NO".

The Hartford's Estimated Earnings for 1982 from Colorado Doctors to Be over \$3 Million

Today's widely varying interest rates and earnings potential on long-term investment dollars will allow The Hartford to recapture an estimated 30% of the total premium dollars to be paid by Colorado physicians in 1981-82. That means that 30 cents out of every premium dollar you pay will remain in Hartford, Connecticut, or in market-basket investments made by The Hartford.

How can the Colorado Medical Society reduce the cost of insurance coverage for its members? K. Mason Howard, M.D., President of CMS, says the cost of insurance will not be immediately reduced to the individual physicians; however, long-term gains which can be returned to the physicians can be great. As an example, earnings on those dollars, which are held in reserve for claims and defense, can remain in Colorado and go toward stabilizing premium rates in years to come. Howard points out that nothing is constant in today's economy, and therefore the inflation rate and normal year-to-year business administration costs will continue to rise. If, at the same time, a Colorado captive insurance company can work to stabilize that premium, or work to reduce the increase in premium, the captive will work to the advantage of every Colorado Medical Society member.

Dr. Howard also points out that the first year of this transition will continue "business as usual," because The Hartford will continue to re-insure each member beyond the first \$50,000 coverage, and there will still be only a single payment for your premiums.

Dr. Howard adds that the built-in advantages of this transition will enable CMS to continue working with its brokerage firm, Warren & Sommer, while the same, high-quality service will be afforded to all of our in-state administration in the program. Howard points out examples of what other states have done with captives (now numbering 27 successful individual state captives in operation). He says he only regrets that the Colorado Medical Society was so long in realizing the need for the change and the difficulty in educating its members to the change at this time.

CMS-Warren & Sommer on the Road to Educate Physician Members About Trust

Starting in early May, Colorado Medical Society Executive Committee members, staff and executives from Warren & Sommer, M.L.C.P., and others began a vigorous schedule of meetings in which they are reviewing the CMS Trust program and its ad-

vantages. The activities spread throughout the state, providing all component and specialty societies and hospital or P.C. groups the opportunity to see the program, then ask questions of those who have developed the program and are now involved in this intensive campaign.

The primary concern of CMS and the PLI Trust is to contact as many members of CMS and those physicians insured by The Hartford to participate in the Trust by the time their malpractice insurance policy is renewed.

Gene Mapes, Executive Vice President of Warren & Sommer, recently addressed CMS members by saying that a commitment is needed from the membership, before the trust program and then the captive, can be given wings. Mapes said the best way to do this is to have each physician make a written and a cash commitment ... sign the agreement, and enclose \$100.00 with that document. Mapes added: "All those who have received the information packet have been asked to read the terms and conditions of the trust agreement, sending it with a check for \$100.00 to Warren & Sommer. THIS IS NOT A CONTRIBUTION! Each person submitting this check will have the amount applied to next year's premium through Warren & Sommer's normal procedures."

CMS Officials Available For Any Group Who Wants to Know About The Trust

The last half of May is a busy time for the CMS Trust information meetings, according to R.G. Bowman, Executive Vice President of CMS, and the schedule was established well before the program started, he said.

According to Bowman, there have been necessary changes, so it would be of little avail to reprint the May and June schedule here. However, Bowman added, "you can find out from your component or specialty society officers or staff, and if you want a special meeting you can arrange this through CMS offices. The program has just begun! July is as good a time to find out as any, if you haven't heard already. Don't hesitate to get in touch with CMS offices if you want more printed information or if you want an executive or a staff presentation."

CMS Officers See Reason for Change in Malpractice Insurance Program

Colorado Medical Society leadership has spoken to the need for changes in the professional liability insurance program, and the House of Delegates approved the change.

The primary reason for seeking change, according to members of the Board of Directors, is to develop control of the program in Colorado, by Colorado physicians. The second reason was to retain all of the investment income from this \$14 million program (1981-82 premium dollars to be paid in) in Colorado, for Colorado physicians.

As a result of the Board's decision, the CMS Professional Liability Insurance Trust has been created. The Trust will perform a one-year transitional operation to move CMS membership to a captive insurance program by July 1, 1982. Already, CMS members see the value of this Trust, for it will cover each insured for the first \$50,000 liability, after which The Hartford will continue to supply reinsurance up to the limits of the physician's policy coverage. This will allow the Colorado Physicians Insurance Company to build the reserves and fund the capital requirements to be in business by July 1, 1982.

Hartford Announces A 10% Increase in 1981-1982 Premium

Whether you renew with The Hartford or whether you join the CMS Professional Liability Insurance Trust, your premium for 1981-82 malpractice insurance will be increased by 10%. That's the word from The Hartford during the long negotiations between their officers and CMS executives.

David Bates, M.D., member of the Executive Committee of CMS and a long-time participant in negotiations with The Hartford, reminds CMS members that all costs are going up, and the announced increase by The Hartford is a typical two-digit inflationary rise in the cost of malpractice coverage.

Members of the Executive Commit-

tee, in their meeting of April 24, 1981, pointed out that the creation of the CMS PLI Trust will, in no way, avoid the increase in premium cost. However, the creation of the trust would, they said, aid in stabilizing premium costs in the future.

Frederic Lewis, Jr., M.D., President-elect of CMS, told members that this was not a short-range, dollar-saving program. He said he was comfortable in looking to some physician-return on trust participation within a 3 to 5 year period. Dr. Lewis said the successes made by other state-owned captive insurance companies indicates that 5 years experience in operating such a captive has shown that period to be a typical success pattern for the doctor-owned captive.

Dr. Lewis added that "I expect to see the doctor-participation in the trust (and then the captive insurance company), to be a mutually-attractive investment for the individual physician and for the entire CMS membership."

What Is "Aggregate Stop-Loss" Insurance?

Since commencing discussion of a Colorado physician-owned captive insurance program, many physicians have heard the term, "aggregate stop-loss policy." What does it mean?

K. Mason Howard, M.D., President of CMS, explained to the House of Delegates at the Interim Session in March, and again before the Board of Directors on April 24, 1981, just what this means:

"Aggregate stop-loss insurance is no more than CMS purchasing insurance on the open market to protect its Trust from losses (claims settled) beyond its collected premium plus earnings. For instance, in the first year (July 1, 1981, to June 30, 1982) the CMS Professional Liability Insurance Trust will underwrite insurance coverage up to the first \$50,000. Thereafter, The Hartford will act as the reinsurance agent, providing basic limits coverage up to \$200,000/\$600,000, and excess limits coverage up to \$5 million. What this amounts to is a deductible insurance policy being underwritten by the CMS PLI Trust.

"That is 'aggregate stop-loss coverage'."

CMS President Addresses Membership About Trust Participation

May 5, 1981

Dear Doctor:

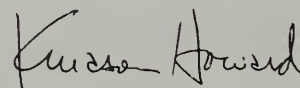
After several years of study, negotiations with Hartford, and a Colorado Medical Society Professional Liability Study, an exciting decision has been made! The CMS plans to establish its own captive insurance company within the next 12 months. In order to accomplish this we have:

- 1) negotiated an understanding with Hartford.*
- 2) established a participatory trust that your membership now will give CMS a greater share in the program's control and ultimate funding of the captive, and*
- 3) started the legal and administrative steps to offer you a better Professional Liability program by June 1982 through you own captive.*

Our series of statewide meetings and an information kit for each member all attempt to explain in detail this program within the next few weeks. I recommend strongly that you review the material and attend one of the meetings on the new program.

IF YOU WISH TO PARTICIPATE IN THE PROGRAM you only need sign the participation agreement and return it to Warren & Sommer with the \$100 fee, which will be the amount that will be credited your malpractice premium when it is paid.

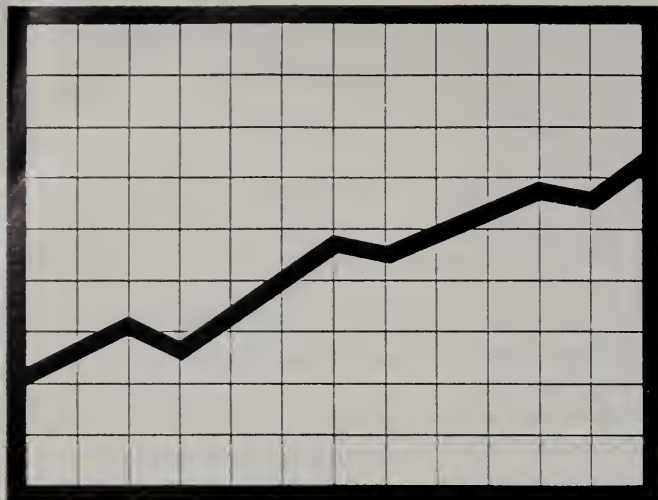
Sincerely,



K. Mason Howard, M.D.
President

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MALPRACTICE AWARDS KEEP CLIMBING!

Colorado Physicians Form Insurance Trust
To Combat Ever Increasing
Insurance Costs!

June 1981 marks the beginning of the Colorado Medical Society Professional Liability Insurance Trust (CMS - PLIT)!

After months of negotiations with The Hartford Insurance Company, the CMS Executive Committee came to the unanimous decision that the only way to combat the rising costs of ever-increasing malpractice awards, and the continuing threat of frivolous suits against physicians was to work toward self insurance. **That is what is happening!**

The CMS Professional Liability Insurance Trust is the first major step toward a Physician-Owned Captive Insurance Company.

**YOU NEED THE TRUST!
THE TRUST NEEDS YOU!**

Call today! Get full details on what the CMS-PLIT means to you! If you have not received the Professional Liability Insurance Trust Program details (an information packet was sent each member in early May), call the CMS office at 861-1221 or (WATS line) 1-800-332-4150!

Every Colorado physician needs the Trust!

The Trust needs the participation of every Colorado physician!

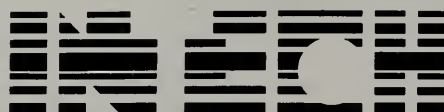
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On target for the functional bowel/irritable bowel syndrome*

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- ⊕ freedom to choose and titrate concomitant medication when a psychogenic disorder coexists

On target means

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- ⊕ bioavailability of all dosage forms that encourages therapeutic effect
- ⊕ significant pharmacologic activity that can be demonstrated at the target site in the distal colon (Figure 1)

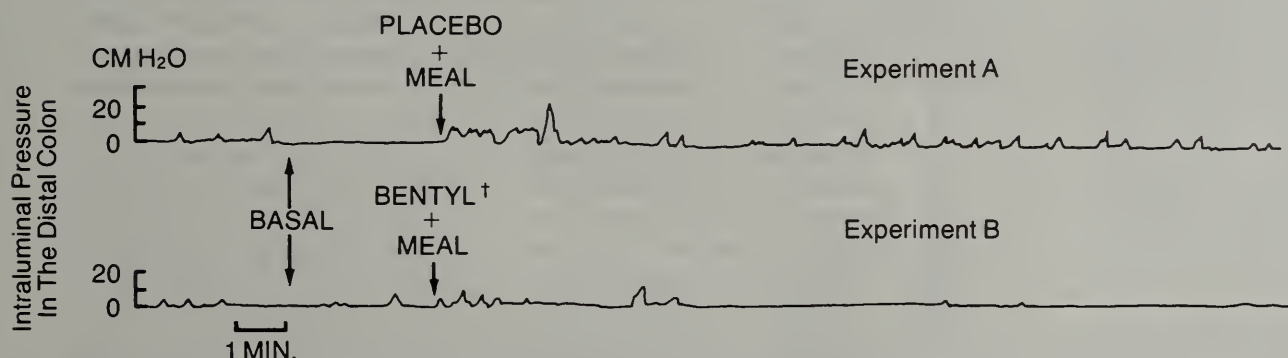


Fig. 1. In ten irritable colon patients, the mean motility index for the colonic wave patterns following a meal and intramuscular placebo was calculated at 86 ± 28 . On a separate day, the mean motility index for the colonic wave patterns following a meal plus intramuscular Bentyl was calculated at 14 ± 8 . The decrease in motor activity induced by Bentyl[†] was statistically significant ($p < 0.05$) in spite of the wide range of the standard error of the mean. The above graph illustrates the intraluminal pressure findings in one of the patients typical of the group studied.

*This drug has been classified "probably" effective for this indication.

from a study by A.R. Chowdhury
and S.H. Lorber, 1980

[†]Although the dose of Bentyl used to show pharmacologic effect was 50 mg., which is a higher single dose than that permitted in the labeling, the dose was considered justified, since the recommended daily dose of injectable Bentyl is 20 mg. (2 ml.) every 4 to 6 hours. Thus, in 8 hours, a patient could receive a total of 60 mg. I.M. and, at that time, as a result of the sustained plasma levels from the 20 mg. injections at 0 and 4 hours, might show an even higher plasma level than occurs after a single 50 mg. dose. Presumably, the same pharmacologic effect, as shown in Figure 1, would follow. These observations do not constitute evidence of efficacy.

Merrell

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Brief Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.
For use in the treatment of infant colic (syrup).
Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis.

WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. There are rare reports of infants, 6 weeks of age and under, administered dicyclomine hydrochloride syrup, who have exhibited respiratory symptoms (breathing difficulty, shortness of breath, breathlessness, respiratory collapse, apnea), as well as seizures, syncope, asphyxia, pulse rate fluctuations, muscular hypotonia, and coma. The above symptoms have occurred within minutes of ingestion and lasted 20 to 30 minutes. The timing and nature of the reactions suggest that they were a consequence of local irritation and/or aspiration rather than a direct pharmacologic effect. No known deaths or permanent adverse effects have been reported. Bentyl syrup should be used with caution in this age group.

PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy.

Use with caution in patients with:
Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon.

Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension.
Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of light-headedness and occasionally local irritation.

DOSEAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage
Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (Dilute with equal volume of water.)

Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily.
Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only.
NOT FOR INTRAVENOUS USE.

MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of July, 1980

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John F. Mueller, M.D. Appointed Director

John F. Mueller, M.D., has been appointed to the corporate position of Director of Academic Affairs for Presbyterian/Saint Luke's Medical Center, Denver. Prior to his appointment, Dr. Mueller served as the Director of Medicine at Saint Luke's Hospital, one of the three major teaching hospitals comprising Presbyterian/Saint Luke's.



In his new position, Dr. Mueller will be responsible for the management and direction of education programs and activities of Presbyterian/Saint Luke's in the areas of Undergraduate, Graduate and Continuing Medical Education. He will be responsible for developing a plan and organizational framework for all educational activities of the Medical Center, including Allied Health Education.

American Cancer Society Professional Education Update

OVARIAN CANCER: The diagnosis and treatment of ovarian cancer are discussed in-depth in this two-part article. The first section presents information on incidence and mortality; early detection and prevention; and diagnosis, clarification and staging, with emphasis on the Post-menopausal Palpable Ovary Syndrome. In part two, treatment is described in terms of tumor cell type and stage of disease. The challenging and difficult problem of ovarian cancer in children is also examined.

THE RADIOLOGY OF BONE TUMORS: The value of radiology in the diagnosis and management of bone tumors is thoroughly and clearly presented. Topics include: conventional radiographic evaluation; tomography and xeroradiography; arteriography; computed tomography; and percutaneous needle biopsy. This publication should be of interest to all physicians, particularly radiologists.

Patient education order blanks are available to you for your office.

Grievance of the Month

Editor's Note: the "Grievance of the Month" column was just established in the March issue of Colorado Medicine, and will be appearing monthly as an aid to your private practice. Names, of course, are fictitious, but the circumstances are those reported in grievances handled by your CMS Grievance Committee.

Complaint: Jim Crow writes the Grievance Committee stating that he had an appointment with Dr. Johnson, but at the time of his appointment the doctor was not available, and he was treated by Dr. Johnson's assistant, Bill Black. The office call charge was \$18.00, the same as Dr. Johnson's office call charge.

Investigation: The patient had no complaint regarding the management of his illness, in fact he felt that the P.A.'s attention to his problem was excellent. His complaint was that he had been given an appointment with Dr. Johnson and didn't get to see him. Also Mr. Crow felt that Dr. Johnson's assistant shouldn't charge as much as Dr. Johnson himself.

Disposition: Mr. Crow is advised that it is common practice for a P.A.'s charges to be identical to the physician's. In most cases the P.A. has more time to discuss the treatment and prevention of future disease. Mr. Crow is also advised that if he wished only to see Dr. Johnson that he should make that clear to Dr. Johnson's staff. Dr. Johnson is advised better communication should be attempted educating his patients re: the P.A.'s role and charges. This should be in written form via the monthly statement, a separate mailing, or a hand-out at the reception desk. Also, in cases where Dr. Johnson is not available, the office staff should check with the patient to see if he wishes to see the P.A., wait for the doctor, or make another appointment.

Cost-Containment Medical Education: Colorado's Strategy

Steven R. Lowenstein, MD, Denver, Colorado

In recognition of the self-defeating effects of inflated medical care costs, the Colorado legislature has adopted a resolution that encourages education and research in cost containment medicine. The curriculum that this resolution calls for should lead to a responsible situation for all involved.

Abstract

The cost of medical care is increasing each year, consuming an ever-larger share of the nation's resources. Both regulatory and free-market strategies have been proposed to control health care costs. In Colorado the State Legislature has considered a different approach: the education of nurses and physicians in health care cost containment. A Resolution has been adopted by the Senate, which encourages education and research in cost containment medicine.

Experience suggests that health professionals and trainees can learn more efficient habits of practice, and that costs can be reduced with no adverse effect upon the quality of patient care. Health professionals and legislators can work together, to provide medical care which is efficient, humane, and scientifically sound.

The growing cost of medical care frightens people. In the past thirty years health care costs have increased 1500 percent¹. Expenditures for health are doubling every five years, outpacing wages, inflation in other sectors and the Gross National Product.²

The health cost problem tends to push other issues aside, and it prompts physicians, administrators and legislators to frantic political activity. Public discussion emphasizes two broad

policy options.³⁻⁵ One approach is regulation by government. Rate-review commissions, which audit hospital budgets and reject unnecessary expenditures, and certificate-of-public-need programs are examples of public regulation. A second approach emphasizes the introduction of competition into the medical market-place. Standardization of insurance packages, advertising by providers and the establishment of competing, pre-paid health plans (HMO's) are such options, which allow consumers to make informed choices when purchasing health insurance. Sometimes, competitive and regulatory strategies are combined, in an effort to shore-up missing market forces.*

The Colorado General Assembly has recently considered a simpler strategy: the education of nurses and physicians in health care cost containment. A Resolution has been approved by the State Senate, which asks the University of Colorado Health Sciences Center and other health institutions to include cost-awareness in their curricula.**

Some would say that physicians are the real consumers of the health care industry. They order all the tests. It is estimated that physicians generate 50-75 percent of all personal health expenditures.^{7, 8} Physicians determine laboratory costs, which are the fastest-growing component of hospital care.^{9, 10} Unfortunately, physicians often misuse and overuse the laboratory,^{10, 11} so that overall, only 5 percent of laboratory information is ever applied to patient care.¹² Public attention is drawn to the costly CAT scans; the repetitive misuse of common laboratory technologies costs us more.¹³

Reprint requests to: Steven R. Lowenstein, M.D., Department of Medicine, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Box B-178, Denver, Colorado 80262.

*One example is provided by Public Law 96-79. In these amendments to the National Health Planning Act, the Congress directs all Health Systems Agencies to encourage competition in the private sector (6).

**State Senator Barbara Holme sponsored Colorado's Cost-containment resolution.

During our medical training we do not learn enough about costs. It is not surprising that most students and physicians do not know the costs of goods and services ordered for patients. At the Medical College of Ohio only 30 percent of trainees could guess the price of tests within a 25 percent range.¹⁴

We learn to examine patients and to formulate diagnostic and therapeutic plans. But there is no cost effectiveness component to our formulations. For the patient who is bleeding, and for the one with a myocardial infarction, no one asks: "Which tests are essential, and which ones are superfluous, misapplied or a waste of money?"¹⁵ That is the purpose of cost-containment education in medicine—to teach trainees about costs and to encourage an attitude of concern.

Usually, a cost-savings in the teaching hospital can be realized.¹⁶⁻¹⁸ In addition, attention given to costs can result in improvement of practice habits. "Querying a house officer as to whether the use of a specific test will alter diagnosis, treatment, or outcome sharpens clinical logic and leads to more careful evaluation of the care he is giving his patients."¹⁷

Cost-containment medical education is different from the national Voluntary Effort, which emphasizes prudent purchasing, energy conservation, and improved management of hospitals. In addition, cost-containment medicine amounts to more than a "cost-awareness week" or a poster campaign. Education in cost-containment emphasizes the effective integration of clinical and laboratory data and the discriminating application of modern technology for the benefit of patients. It is obvious that cost-containment must be taught by respected clinicians, side-by-side with pathophysiology, differential diagnosis and therapy.¹⁹ New methods of cost-control must also be tested and proven in the customary, scientific manner.

Medical institutions have an obligation to teach cost-containment.²⁰ Already, more than forty U.S. medical schools have program activity in cost-containment medical education.²¹ At Charlotte Memorial Hospital, a cost-containment program reduced hospital length-of-stay 21 percent and lowered the annual rise of hospital costs from 14.5 percent to 4.3 percent.¹⁷ At Duke¹² and George Washington²² audits of students' and physicians' performances have been employed to reduce laboratory use as much as 29 percent. No information is lost when attention is given to costs; there is no demonstrable adverse impact upon patient care.^{10, 12, 23}

Cost-awareness is not a final solution to the health cost crisis. Educators must still consider other inflationary factors in the health industry. The market is ill-structured to contain costs; the current scientific paradigm continues to excite demand and inflation; and changing demographics, an aging population, and a multitude of social and environmental hazards conspire, making it less likely health can be achieved at any cost incurred. In addition, most educators agree that knowledge of costs does not alone determine physicians' behavior; other factors operate, such as the pressure of professional peers, the fear of litigation, laboratory inefficiencies, and the current financing mechanisms (which do not reward clinicians for tests not done).^{16, 24-26} Still, education in cost-efficient medical practices can help, to control costs generated by present and future health professionals.

The Colorado Resolution proposes no new regulation. It does not interfere with the prerogative of health professionals to take charge of medical education or patient care. It does not change the current mix of public and private medical enterprise. The Resolution states that cost-containment medical education is in the public interest, and it is left to the Universities to teach it properly.

The cost-containment Resolution has already had an impact. The Dean of the University of Colorado School of Medicine has assembled a cost-containment education committee to devise a curriculum and plan a research strategy. Committee-members include educators, an economist, an epidemiologist, a hospital administrator and a representative of the health insurance industry.

In Colorado health professionals and legislators have agreed to share the responsibility for medical cost-control. The Resolution was supported by the School of Medicine, the Colorado Medical Society, the Hospital Association, the Nurses' Association and Colorado Blue Cross/Blue Shield. It is expected that the University of Colorado Health Sciences Center will report regularly to the Legislature its efforts and achievements in cost-containment, and it is hoped that communication and trust among physicians and politicians will grow.

Cost-containment is a rightful concern of government and a goal of public health policy. Cost-awareness is also an important duty of the medical profession. Experience suggests that modern medical care can be efficient, and at the same time, humane and scientifically sound.

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Is there a doctor on the road or at the game?



The Committee on Medical Aspects of Sports of Colorado Medical Society hopes to hear from physicians who share its members' interest and concern about medical coverage of running events and interscholastic athletic contests.

Please let us know if you are interested in participating in your community.

I volunteer to be listed in the CMS program to provide medical support services to nonprofit sports events and programs in Colorado.

Name: _____

Address: _____

Telephone: _____

Component medical society: _____

Special Interest
in Sports Medicine: _____

Please mail to:

David C. Greenberg, M.D.
Chairman
Committee on Medical
Aspects of Sports
Colorado Medical Society
1601 E. 19th Avenue
Denver, CO 80218

Problematic Skin Cancer Treatment by Microscopically Controlled Excision

Patrick J. Lillis, MD, Loveland, Colorado

The populace of Colorado suffers an abnormally high incidence of sun-induced basal and squamous cell carcinomas. The occurrence of these neoplasms is directly related to total lifetime cumulative sun exposure.

The potential for exposure to large cumulative doses of sun exposure in Colorado is great because of the large number of relatively cloudless days. Also the significant elevation decreases the amount of atmosphere through which the ultraviolet radiation from the sun must pass. This atmosphere, especially the ozone layer, helps to filter out the damaging ultraviolet rays.

The significant percentage of the population involved in agricultural pursuits and the cosmetic desirability of "tanning" over the past two or three decades are additional factors influencing the skin cancer rate.

Approximately 80 percent of skin cancers are of the basal cell carcinoma variety. Metastases of basal cell carcinoma can occur, but this phenomenon is so rare as to not be a consideration in evaluation and treatment of this tumor.

About 15 percent of the skin cancers are sun induced squamous cell carcinoma. The overwhelming majority of these arise from actinic keratoses. Sun induced squamous cell carcinoma of hair-bearing skin has a consistently low metastatic potential of about one to three percent. Sun-induced squamous cell carcinoma of the lip, however, has a metastatic rate of closer to 10 percent.

Treatment of most skin cancers is both simple and effective. Greater than 90 percent of sun-induced basal and squamous cell carcinoma can be effectively treated by conventional methods such as curettage and desiccation, surgical excision or, in the elderly, radiation therapy.

A small percentage of skin cancers, however, are more troublesome in that they repeatedly recur after attempts at treatment by conven-

tional methods. It is this select group of lesions for which a highly specialized type of "microscopically controlled excision", historically referred to as "Mohs Chemosurgery", is extremely effective and usually, when available, the treatment of choice.

How does one predict which lesions will respond to simple conventional methods and which are likely to need more specialized treatment? The anatomic location of the tumor and histologic pattern can identify previously untreated tumors which have a significant potential for recurrence after conventional therapy. More importantly, however, any tumor which has already recurred after previous treatment has about a 50 percent of re-recurrence when retreated by the same modality.¹ The skill of the surgeon, the amount of normal tissue sacrificed to obtain clear margins and the degree of microscopic control are factors which can affect the re-recurrence rate, however. These factors will be discussed in more detail later in this presentation.

Historical Background

In the mid-1930's Dr. Fredric Mohs developed a method for dealing with large and recurrent basal and squamous cell carcinomas of the skin which involved application of a zinc chloride fixative paste to the tumor under an occlusive dressing which was usually left on overnight. This would "fix the tissue in situ" while at the same time preserving the histologic detail. The following day a thin saucerized specimen of fixed tissue would be taken, and the undersurface and periphery checked for residual tumor by frozen section. If tumor remained, the paste would then be reapplied at the specific location of involvement and another layer taken the following day. By this method, the unpredictable "roots" of the tumor could be traced out in a systematic step-by-step

fashion. Dr. Mohs' success rate was unequalled in dealing with difficult and repeatedly recurrent cutaneous malignancies. In spite of this, his technique was practiced by only a small number of physicians prior to the 1970's.

The primary reason for the limited usage of Mohs' Chemosurgery was that the technique was extremely tedious and time consuming. Usually only one layer could be taken each day. Therefore, extensive cases would take many days and sometimes weeks to complete.

Immediate reconstruction could not be done because of the residual fixed tissue remaining after tumor eradication. It was common practice to let the wounds heal by secondary intention and wait one year before attempting any repair in order to detect any recurrences at the earliest possible time.

In 1953 Dr. Mohs began successfully removing tumors of the eyelid margin without the zinc chloride paste in order to avoid eyelid irritation. In the late 1960's Dr. Tromovitch began using this "fresh tissue technique" at all cutaneous sites. His long-term cure rates essentially equalled the "fixed tissue technique" cure rates.² These statistics have been borne out by many other "Mohs Surgeons" in the last decade. Today the fixed tissue technique is rarely used.

The fresh tissue technique has a number of important advantages over the fixed tissue technique. Up to 8-12 layers can now be done in a single day. Most cases, therefore, can be completed in the same morning or at least in the same day. More importantly, immediate reconstruction can be accomplished when deemed appropriate. As the consistently excellent cure rates with the "fresh tissue technique" have become apparent, "Mohs Surgeons" have become much less reluctant to perform or refer for immediate reconstruction.

The term Mohs' Chemosurgery has now become a misnomer because the chemical fixative is rarely used. Now the Mohs' "fresh tissue technique" is often referred to as "microscopically controlled excision (MCE)".

Materials and Methods

The treatment area is anesthetized with 1 percent xylocaine with epinephrine. All obvious tumor is removed with either a curette or scalpel. A thin (1-3mm) piece of tissue is then removed in a saucerized fashion from around and underneath the resultant defect (Fig. 1). This "flat" specimen

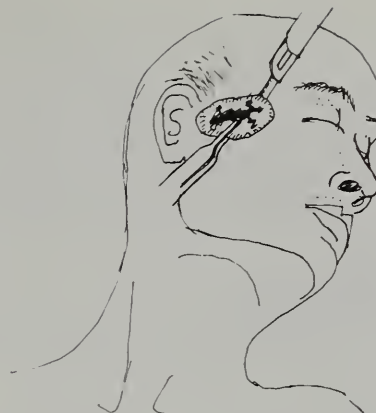


Figure 1. Tissue is excised from the involved area in a saucerized manner.

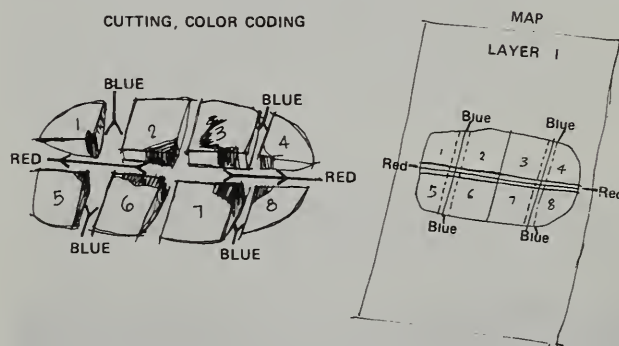


Figure 2. The specimen is divided into 1 cm. sections. A corresponding map is drawn and the edges are color coded.

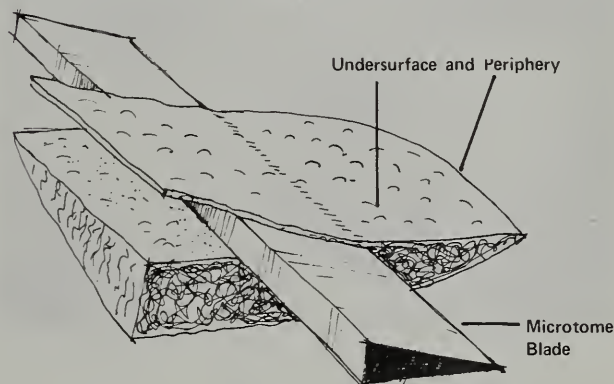


Figure 3. Horizontal sections are then taken from the entire undersurface and periphery.

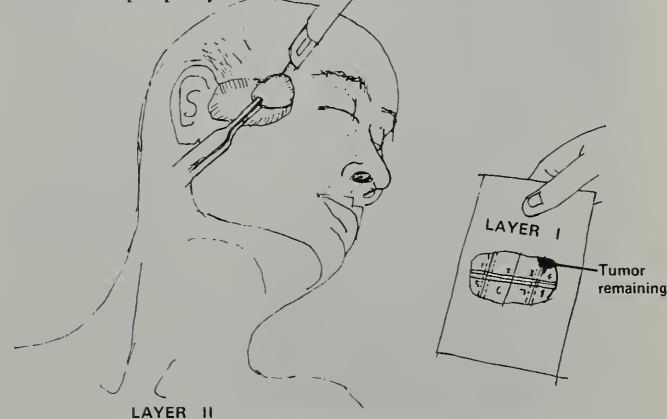


Figure 4. After microscopic examination another layer is taken from any area where tumor is found.

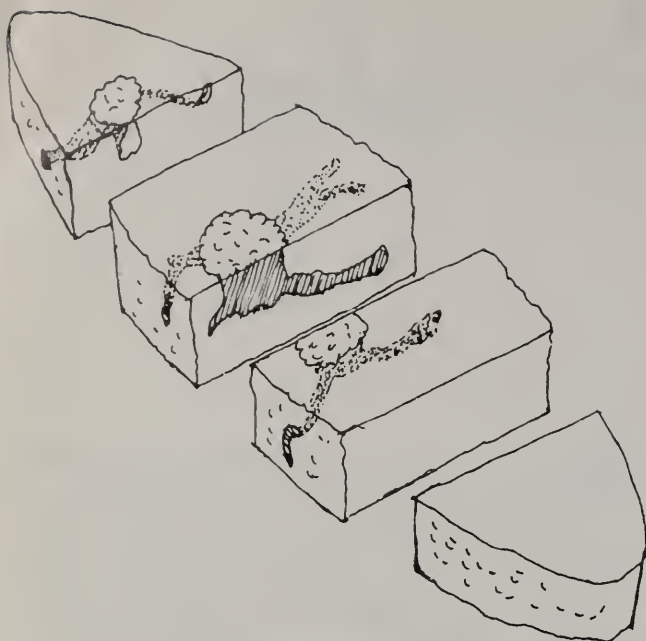


Figure 5. This 3 dimensional diagram illustrates how slender strands of tumor can escape detection when margins are determined by standard step sectioning.

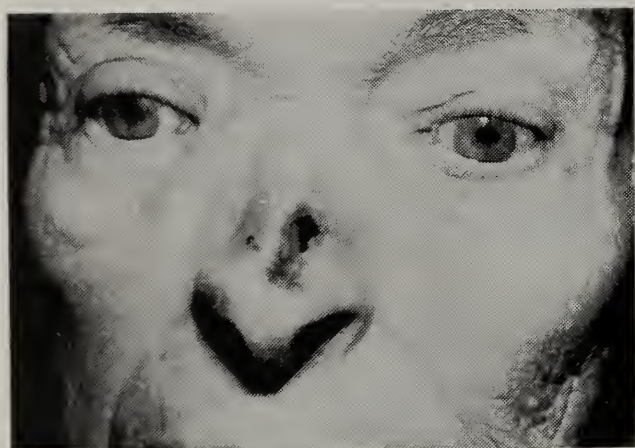


Figure 6. This patient had had a 30 year history of a BCC recurrent after approximately 14 attempts at treatment.



Figure 7. After 7 layers a tumor-free plane was reached. The sparing of the alar rim illustrates the "tissue sparing" aspect of the MCE and will be important to the cosmetic outcome.

of tissue is then divided into pieces small enough to fit on a microscope slide (Fig. 2).

A map is drawn of the specimen and where it was divided. The edges of each divided specimen are then dyed with either a permanent red, blue or black dye. The dyes are indicated on the map with symbols (--- is blue, — is red) (Fig. 2).

Each flat specimen is then mounted, undersurface up, on the cryostat button, and horizontal sections are taken in such a fashion that they include the entire undersurface and periphery of the specimen (Fig. 3). After staining, each section is examined immediately under the microscope. Since we are viewing the "entire undersurface and periphery" there is theoretically no margin for error. If tumor is seen the exact location is marked on the map. A layer of tissue is then taken from the corresponding site on or around the existing defect and processed in the same manner (Fig. 4).

This systematic step-by-step approach insures total tumor removal with maximum sparing of normal tissue. The tissue sparing is a very important feature of this technique, especially in lesions around the nose and eye.

Most patients are referred for immediate repair. Because the defects are frequently large, flaps and grafts are often necessary.

Results

Dr. Tromovitch, with the fresh tissue technique, obtained a cure rate of 97.2 percent in 532 lesions (432 patients) which were followed from two to eight years. Fifty-four percent of the lesions had recurred at least once after conventional therapy (curettage and desiccation, surgical excision, or x-ray therapy). Twenty-two percent of the defects were greater than 3 cm. and many were greater than 6 cm. The size of the defects are especially significant because 80 percent of the lesions were on the face. Twenty-three percent of the lesions were in the 30-50 age group.³

In this series Dr. Tromovitch had nine recurrences. Seven of these were subsequently retreated by the Mohs technique without recurrence.

In a series of 213 recurrent basal cell carcinomas treated by the Mohs technique at New York University Skin and Cancer Unit, a 96.3 percent cure rate was obtained with a three year followup.³

Indications

Menn *et al.* reported that tumors recurrent

after any of the three conventional modes of therapy (curettage and desiccation, surgical excision, radiation therapy) had a re-recurrence rate of 49.3 percent if retreated by any one of these same methods. Kopf reported a re-recurrence rate of 34 percent for retreatment by curettage and desiccation.⁴ These statistics and a number of other studies strongly suggest that recurrent basal cell carcinomas and squamous cell carcinomas are an indication for the use of MCE.

Morpheaform, or sclerosing, and fibronodular basal cell carcinomas send out thin strands of tumor in unpredictable directions which are clinically indistinct. Figure 5 illustrates how standard vertical sectioning to check margins can miss these extensions and lead to a recurrence even when the margins have been reported as clear. The morpheaform, or sclerosing, and fibronodular basal cell carcinoma is another indication for treatment by MCE.

Incidence of recurrence after treatment with conventional methods. The anatomical areas in which skin cancers are most likely to recur and recur are in the central portion of the mid face and the auricular and preauricular areas.⁵

Specifically, the nasal dorsum, nasal tip, nasal ala, nasolabial fold, philtrum, inner canthus, outer canthus, postauricular sulcus, pretragal region, helix, tragus, antihelix, concha and ear-

lobe are reported to be areas of high recurrence.⁵ Any lesions of significant size (clinically approaching or greater than 1 cm.) with morpheaform or sclerosing characteristics or recurrent lesions in these locations should be considered indications for treatment by microscopically controlled excision.

Advantages and Disadvantages of Microscopically Controlled Excision

The disadvantages of Mohs Chemosurgery (fixed tissue technique) versus the advantages of the fresh tissue technique (MCE) have been previously discussed. The disadvantages of the fresh tissue technique (MCE) are that it is still somewhat time-consuming and tedious, it requires training in surgery and histopathology, it requires an assistant, a laboratory, a cryostat, and a cryostat technician.

The primary advantages of MCE are an unequalled cure rate, even for repeatedly recurrent carcinomas and, just as importantly, maximal conservation of normal tissue. This allows superior cosmetic results to be obtained by appropriate referral for early repair. Additionally, significant cost savings result because subsequent treatments are rarely necessary and because this is an outpatient office procedure.

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Critical care monitoring

Ernest L. Dunn, MD, and Ernest E. Moore, MD, Denver, Colorado*

Over the past two years critically ill patients at the Denver General Hospital have been treated with aggressive cardiopulmonary analysis. The monitoring system includes a thermodilution pulmonary artery catheter and an arterial line. The result has been an accurate physiologic assessment of the patient's status and improved patient care.

Monitoring of the critically ill patient has gained sophistication at an astonishing rate. The result has been new insights into multiple system alterations and their interplay in the acutely ill patient. Over the past two years, at Denver General Hospital, we have used a system of aggressive cardiopulmonary monitoring in treating surgical patients admitted to the intensive care unit. In instituting this system, several requirements were kept in view. The invasive monitoring devices had to add minimal morbidity for the patient. The measured and derived parameters needed to be readily reproducible and available for the physician to utilize. The third demand was that the system be of low cost.

Technic

Critically ill patients admitted to the intensive care unit received percutaneous placement of a thermodilution flow-directed pulmonary artery catheter. This was inserted at the bedside with electrocardiography and pressure monitoring.¹ These patients were usually too unstable to be transported to radiology for catheter placement under fluoroscopy. Pressure tracings alone permitted accurate placement of the pulmonary artery catheter in all patients, and its position was then confirmed by portable chest film. An arterial line was placed for the measurement of sys-

temic pressures and the sampling of blood gases.

Our system was housed in a mobile cart which could be used throughout the intensive care unit, operating rooms, or recovery room. The equipment included a two-channel pressure monitor, which allowed simultaneous reading of pulmonary and systemic arterial pressures, and a thermodilution cardiac output computer. The thermodilution system was chosen since measurements could be reported frequently as ventilatory manipulations and pharmacologic interventions were made. The nursing service was capable of performing the studies and recording the results on the patient's bedside data sheet. The measured parameters were then entered in a programmable hand-held calculator to derive additional cardiovascular and pulmonary parameters.

The measured hemodynamic indices were systolic, diastolic, and mean systemic arterial pressures; systolic, diastolic, and mean pulmonary artery pressures; pulmonary capillary wedge pressure; central venous pressure, cardiac output, and heart rate. Height and weight were used to calculate body surface area. From these data, multiple derived parameters were obtained. These included left ventricular stroke volume and stroke work, systemic vascular resistance, and pulmonary vascular resistance (Table I).²

The knowledge of arterial and mixed venous blood gases, hemoglobin, and cardiac output enabled further calculation of multiple pulmonary parameters. These were arterial and venous oxygen content, pulmonary shunt, arteriovenous oxygen difference, oxygen delivery, oxygen consumption, and oxygen utilization (Table II).² The entire set of cardiopulmonary data was available within one hour of admission to the intensive care unit. Re-evaluation was done every eight hours or more frequently depending on the patient's course. Three case histories are presented to illustrate the use of this monitoring.

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CASE REPORTS

Case 1: An eighty-five year old man was admitted with a fever of 39°C, a recent history of weight loss, and the sudden appearance of a right upper quadrant abdominal mass. There was gross purulent drainage from the mass with surrounding erythema and tenderness. Broad spectrum antibiotics were begun, and the patient underwent emergent abdominal exploration with local anesthesia. This disclosed a large infected metastatic lesion in the right lobe of the liver. Multiple drains were placed, and the patient admitted to the intensive care unit. Six hours after surgery, the blood pressure dropped precipitously to 70/40mmHg, the heart rate increased to 124/min, and the urine output ceased. An electrocardiogram showed no evidence of ischemia, and a chest film showed no acute changes. The etiology of this hypotension was uncertain but sepsis, hypovolemia, and myocardial failure were all potential factors.

A Swan-Ganz catheter and an arterial line were placed, and cardiopulmonary analysis performed (Table III). These studies demonstrated a cardiac index of 3.1 L/min/m², a pulmonary capillary wedge pressure of 18mmHg, and a systemic vascular resistance of 436 dyne/sec/cm⁵ (1/3 of normal value). With this information it was felt that the effective circulating blood volume was adequate, and further fluid administration would be detrimental. There was evidence of depressed ventricular function with peripheral vasodilation, most compatible with overwhelming sepsis. The patient was continued on his antibiotics, given a bolus of corticosteroids, and started on dopamine at 10 mg/kg/min. Eight hours after institution of dopamine, the blood pressure was 120/79mmHg, cardiac index was stable at 2.9 L/min/m², systemic resistance had returned to normal (1539 dyne/sec/cm⁵), and urine output increased to greater than 30cc/hr. The patient was gradually removed from the dopamine over the next twenty-four hours without further complications. There was improvement in left ventricular function during this period, as evidenced by increased stroke work and decreased pulmonary wedge pressure.

Comment: This case demonstrated the ability of the monitoring system to elucidate the source of hypotension in an elderly patient. By carefully following the hemodynamic response to dopamine, the patient was gradually weaned from this pharmacologic support when the sepsis was under control.

Case 2: A twenty-four year old man sustained blunt abdominal trauma in a motor vehicle accident. Over the ensuing four weeks he underwent three operative procedures for a severe pancreaticoduodenal injury complicated by biliary fistula and pancreatic abscess formation. During this period he developed progressive respiratory insufficiency and required an inspired oxygen of 80% to maintain a pO₂ of 49mmHg while on mechanical ventilation. A Swan-Ganz catheter was placed, demonstrating a cardiac index of 4.4 L/min/M², and a pulmonary shunt of 42% (Table IV). In spite of the poor arterial saturation (83%), he was able to maintain a normal oxygen delivery to the peripheral tissues due to the elevated cardiac output. Positive and expira-

Table I

| DERIVED CARDIAC PARAMETERS | | |
|-----------------------------------------|-------------------------------------|------------------------------------|
| Parameter | Derivation | Normal Value |
| Cardiac Index (C.I.) | C.O./B.S.A. | 3-4 L/min/m ² |
| Systemic Vascular Resistance (S.V.R.) | $\frac{(MAP-CVP) \times 80}{C.O.}$ | 1200-1400 dyne/sec/cm ⁵ |
| Stroke Volume (S.V.) | C.O./H.R. | 50-60ml |
| Left Ventricular Stroke Work (L.V.S.W.) | S.V. X (MAP-PCWP) X .0136 | 60-80gm-m |
| Pulmonary Vascular Resistance (P.V.R.) | $\frac{(MPA-PCWP) \times 80}{C.O.}$ | 200 dyne/sec/cm ⁵ |

C.O. = cardiac output
 B.S.A. = body surface area
 MAP = mean arterial pressure
 CVP = central venous pressure
 H.R. = heart rate
 PCWP = pulmonary capillary wedge pressure
 MPA = mean pulmonary artery pressure

Table II

| DERIVED PULMONARY PARAMETERS | | |
|----------------------------------------------------------|--------------------------------------------|-----------------|
| Parameter | Derivation | Normal Value |
| Arteriovenous Oxygen Difference (A-VO ₂ Diff) | C _a -C _v | 3.5-4.5ml/100ml |
| Oxygen Delivery (O ₂ Del) | C _a X C.O. X 10 | 1000ml/min |
| Oxygen Consumption (O ₂ Cons) | C _a -C _v X C.O. X 10 | 200-250ml/min |
| Oxygen Utilization (O ₂ Util) | $\frac{O_2 \text{ Cons}}{O_2 \text{ Del}}$ | 20-25% |
| Pulmonary Shunt | $\frac{C_c - C_a}{C_c - C_v}$ | < 10% |

C_a = arterial oxygen content
 C_v = venous oxygen content
 C_c = pulmonary capillary oxygen content

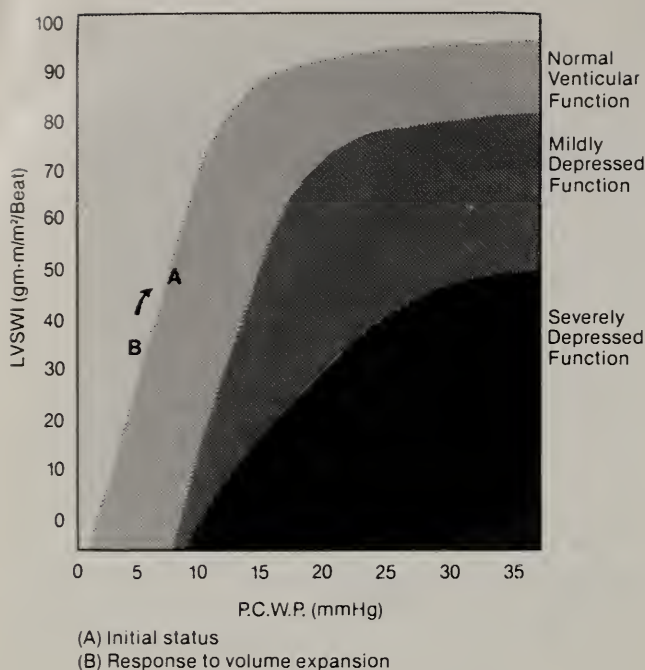
Table III

| CRITICAL CARE MONITORING OF CASE #1 | | | | | |
|-------------------------------------|------|----------|--------|----------|-----|
| | C.I. | P.C.W.P. | S.V.R. | L.V.S.W. | MAP |
| SHOCK | 3.1 | 18 | 436 | 19.3 | 50 |
| DOPAMINE | 2.9 | 16 | 1539 | 30.2 | 90 |
| RECOVERY | 3.2 | 15 | 1350 | 37.3 | 89 |

Table IV

| CRITICAL CARE MONITORING OF CASE #2 | | | | | |
|-------------------------------------|------|------------|---------------------|----------------------|-------------------------|
| | C.I. | PUL. SHUNT | O ₂ DEL. | O ₂ CONS. | INSPIRED O ₂ |
| ARDS | 4.4 | 42% | 957 | 311 | .80 |
| 20cm PEEP | 4.8 | 26% | 1420 | 324 | .40 |

Figure 1. Hemodynamic Profile of Case 3



tory pressure was instituted and gradually increased over the next few hours, carefully determining the cardiovascular response to each change. Twenty hours later the patient had a pO_2 of 57 mmHg on 40% inspired oxygen and 20 cm PEEP. During these adjustments in ventilation, the cardiac index remained stable at 4.8 L/min/m² without pharmacologic intervention. The pulmonary shunt decreased to 26%. Oxygen delivery and oxygen consumption were maintained despite the acute respiratory failure, and eventually the patient was weaned from the ventilator.

Comment: We were able to treat this pulmonary insufficiency aggressively by constantly monitoring the patient's cardiovascular responses to ventilatory adjustments. With the addition of PEEP, the FiO_2 was reduced to a non-toxic level without jeopardizing oxygen delivery and its subsequent utilization.

Case 3: A seventy-one year old lady with a history of hypertension and angina underwent an elective aorto-bifemoral vascular graft for an abdominal aortic aneurysm. In the recovery room the patient became progressively hypertensive (170/110 mmHg) and tachycardic to a rate of 120 beats/min. Urine output had been adequate throughout the operative period, but now had suddenly decreased. There was reluctance to increase the postoperative fluid in view of the patient's age, prior cardiac history, and present hypertension. A Swan-Ganz catheter was placed which demonstrated a pulmonary wedge pressure of 4 mmHg, a cardiac index of 2.2 L/min/m², and a left ventricular stroke work of 51 gm-m. The systemic vascular resistance was elevated to twice normal level (2812 dyne/sec/cm⁵). The plotted left ventricular function, however, appeared normal despite the prior cardiac history (Figure 1).³ Based on this information, the patient received six liters of Ringer's lactate over the next twenty-four hours to match the apparent third space loss. Constant monitoring demonstrated progressive hemodynamic

improvement during this period. At the end of the first postoperative day she had a pulmonary wedge pressure of 8 mmHg, a cardiac index of 3.8 L/min/m², and left ventricular stroke work of 74 gm-m. The systemic vascular resistance returned to normal, hypertension and tachycardia resolved, and urine output continued at 40 cc/hr. Volume expansion did not change pulmonary function, and the patient was managed with supplemental nasal oxygen.

Comment: Third space fluid loss can be significant during a large retroperitoneal dissection. The postoperative fluid management is often difficult, particularly in elderly patients with suspected compromised myocardial function. Monitoring of this patient enabled us to assess her ventricular contractility and improve cardiac output by increasing the left ventricular filling pressure.

Discussion

The cardiopulmonary monitoring system in use at Denver General Hospital allows for the rapid physiologic assessment of the critically ill patient. We have encountered no complications associated with the introduction and utilization of the Swan-Ganz catheter. Ventilatory manipulations, pharmacologic interventions, and volume loading can be undertaken aggressively based on reliable objective data. The entire mobile monitoring system can be acquired for \$10,000, and the individual patient cost is that of the thermodilution catheter (\$75).

Aggressive cardiopulmonary monitoring is currently used in the management of refractory septic shock and postoperative respiratory failure in the multiply injured patient. Elderly patients with a history of cardiac dysfunction, undergoing both elective and emergent major surgical procedures, are studied preoperatively, in the recovery room, and in the intensive care unit. The result has been an intensified awareness of the patient's physiologic response to disease and surgical therapy. We feel this has improved patient care, decreased overall hospital morbidity and mortality, and is cost effective. ●

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ACKNOWLEDGEMENT

We would like to thank Doctor Teruel Decampo for his assistance and continuing support of improved care for the critically ill patient at the Denver General Hospital.

June

5 The Nephrotic Syndrome. La Junta Medical Center, 1100 Carson Ave., La Junta, Colorado. Contact: Douglas Yoder, Director of General Services. 384-5412.

8-12 Improving Your Teaching Skills: A Workshop—Boston, Massachusetts. Approximately 40 credit hours in Category 1 of the Physicians' Recognition Award. Tuition for the five-day workshop is \$490.00. For further information, contact: Philip Liv, M.D., (617) 732-7359 or Elliott V. Miller, M.D., (617) 726-3538; Harvard Medical School, Department of Continuing Education, Boston, Massachusetts 02115.

12 Congenital Dislocation of the Hip. La Junta Medical Center, 1100 Carson Ave., La Junta. Contact: Douglas Yoder, Director of General Services. 384-5412.

15-20 Family Practice Review. Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Ave., C-295, Denver 80262. 394-5241.

18 Differential Diagnosis of Neurological Symptoms of the Upper Arm. Vail, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Ave., Denver 80203.

19 Management of the Poisoned Child: Perspectives on Infectious Disease Emergencies—Sepsis and Meningitis. La Junta Medical Center, 1100 Carson Ave., La Junta, Colorado. Contact: Douglas Yoder, Director of General Services. 384-5412.

19 Reye's Syndrome Conference. The Crest Resort, Vail, Colorado. Contact: E.M. Feiler, M.D., American Reye's Syndrome Association, 701 South Logan, Suite 203, Denver 80209. 733-0604. (5 hours of AMA Category 1 credit; 5 prescribed hours of AAFP credit).

24 Regional Computerized Tomography/Neuro-radiology/Ultrasound Conference. Department of Radiology, University Hospital, Denver 80262. Contact: Suzanne Warner, 394-7773. (3 hours of AMA Category 1 credit).

24 Health in the Occupational Environment. Julesburg, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

26 Management of Epiglottitis and Croup. La Junta Medical Center, 1100 Carson Ave., La Junta, Colorado. Contact: Douglas Yoder, Director of General Services. 384-5412.

26-27 Use of the CO₂ Laser in Gynecology. Beth Israel Hospital, 1601 Lowell Blvd., Denver 80211. Contact: Beth Israel Conference and Institute Program, P.O. Box 11366, Denver 80211. 303-629-5333. (12 hours AMA Category 1 Credit. Applied for 12 ACOG Cognates).

July

13-17 17th Annual Course in Internal Medicine. Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241. (25 hours of AMA Category 1 credit).

20-23 24th Annual Ruidoso Family Practice Seminar. Inn of the Mountain Gods at Mescalero, New Mexico. Contact: Bob Reid, Convention Director, 412 Bassett Tower, El Paso, Texas 79901. (915) 533-3449. (18 hours of AAFP credit).

22-25 Current Concepts in the Surgical Pathology of the Thyroid, Parathyroid, Thymus, and Mediastinum. Santa Fe Hilton Inn, Santa Fe, New Mexico. Contact: W.J. Levy, M.D., Symposia de Santa Fe, P.O. Box 5175, Santa Fe, New Mexico 87501. (505) 982-1911. (14 hours of AMA Category 1 credit).

7/23-8/20 Controversies 2: An Ongoing Course in the Practice of Pediatrics. Contact: Health Education Department, The Children's Hospital, 1056 East 19th Ave., Denver 80218. (303) 861-6947. (AMA credit available on an hour-by-hour basis).

24 Use of the CO₂ Laser in Ent. Beth Israel Hospital, 1601 Lowell Blvd., Denver, Colorado. Contact: Beth Israel Conference and Institute Program, P.O. Box 11366, Denver 80211. (303) 629-5333. (12 hours of AMA Category 1 Credit).

26 Practical Gastroenterology for the Internist and the Family Physician. Aspen, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Ave., Denver 80262. (303) 394-5241. (15 hours of AMA Category 1 credit; 15 hours of AAFP credit).

7/31-8/2 Ear, Nose, Throat for the Family Practitioner. The Lodge, Vail, Colorado. Contact: Lisa Lee, Associates of Otolaryngology, 950 East Harvard, Suite 500, Denver 80210. (303) 744-1961. (22 CME credits).

August

3-6 24th Annual Pediatrics Postgraduate Course. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241.

3-6 Gynecology. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, C-295, Denver 80262. (303) 394-5241.

9-13 Perinatal Medicine. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. 394-5241. (21 hours of AMA Category 1 credit).

10-13 Perinatal. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Avenue, C-295, Denver 80262. 394-5241. (21 hours of AMA Category 1 credit).

10-14 Aspen Conference on Pediatric Disease, 1981 - Tumors. The Gant, Aspen, Colorado. Contact: J. Thomas Stocker, M.D., Department of Pathology, The Children's Hospital, 1056 East 19th Avenue, Denver 80218. 861-6712. (27 hours of AMA Category 1 credit).

14-15 Use of the CO₂ Laser in Gynecology. Beth Israel Hospital, 1601 Lowell Blvd., Denver. Contact: Beth Israel Conference and Institute Program, P.O. Box 11366, Denver 80211. (303) 629-5333. (12 hours AMA Category 1 Credit. Applied for 12 ACOG Cognates).

14-18 Primary Care Orthopedics. Aspen, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241.

19-22 The Kidney in Systemic Illness: Malignancy, Pregnancy and Connective Tissue Disease. The Given Institute of Pathobiology, Aspen, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241. (16 hours of AMA Category 1 credit; 16 hours of AAFP credit).

20 Anemia Work-Up. Vail, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80203.

29-31 Tutorials in the Tetons: Clinical Cardiology - Diagnostic and Therapeutic Advances. Jackson Lake Lodge, Grand Teton National Park, Moran, Wyoming. Contact: Mary Anne McInerney, Extramural Programs Department, American College of Cardiology.

September

3-5 29th Annual James T. Waring Chest Conference. Longs Peak Inn, Estes Park, Colorado. Contact: Tony Marostica, American Lung Association, 1600 Race Street, Denver 80206. (303) 388-4327. (10 hours of AMA Category 1 credit).

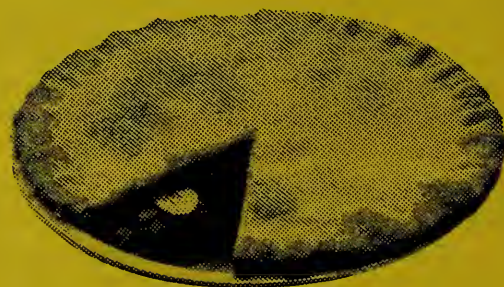
4-6 Pediatric Neurology Mini-Course. Keystone Resort, Colorado. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Avenue, Denver 80218. (303) 861-6949. (AMA Category 1 Credit available).

October

5 What You Should Know About Anticoagulants. Burlington, Colorado. Contact: Martin Rubinstein, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80202. (2 hours of AMA Category 1 Credit; 2 prescribed hours of AAFP Credit).

10-11 The Charley J. Smyth Symposium on Arthritic and Rheumatoid Conditions of the Upper Extremity. The Fairmont Hotel. Contact: John A. Boxwick, Jr., M.D., 4200 East 9th Avenue, Box C-309, Denver. (303) 394-8718. (14 hours of AMA Category 1 Credit).

20-25 General Medicine. Hilton Head Inn, Hilton Head Island, South Carolina. Registration Tuesday, October 20th - 4:00-6:00 p.m. Contact: Beth Israel Hospital, Conference Program, P.O. Box 11366, Denver 80211. Denver Metro Area: (303) 629-5333; Outside Colorado (800) 525-5810.



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Well-qualified clinician including OB for faculty position, university-based family practice residency program. Position involves practice, teaching and administration. Contact: E.S. Farley, Jr., MD, Chairman, Dept. of Family Medicine, Univ. of Colo., 1180 Clermont, Denver, CO 80220. 381-1-2B

Associate Director of family medicine residency training program affiliated with university based program. Position involves teaching, research and administration. CONTACT: F. William Barrows, M.D., 1600 West 42nd Street, Pueblo, CO 81003, (303) 544-5202. 381-1-2B

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FOR SALE: Aurora Medical Clinic, 5 examining rooms, 3 private offices, x-ray room, lab, reception area for doctors, dentist area, plenty of parking. Practice and buildings for sale. Owners retiring and will finance responsible buyers. CALL: Jerry Bartscherer for details. OFFICE: 758-7611, RES: 789-9569. THE DEVONSHIRE COMPANY. 481-1-3B

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PHYSICIAN'S ASSISTANT—Experienced, certified PA desires long-term, stable employment by small town family practitioner. Excellent references. Werner Studer, P.A., Box 264, Yellowstone National Park, Wyoming 82190. 481-1-3B

A Denver ophthalmologist, **Dr. Thomas M. Van Bergen**, who lived at 795 South Alton Way, died March 16, 1981, at St. Luke's Hospital. Dr. Van Bergen was 72.

Dr. Van Bergen was born in Elizabeth, N.J., received his bachelor's degree, master's degree and medical degree from the University of Colorado. He trained in his specialty at the University of Colorado Medical Center, and was an associate professor at the University of Colorado School of Medicine. He married Betty Howard Safford on October 14, 1978, in Denver.

Dr. Van Bergen was a member of the American Board of Ophthalmology, a past president of the Colorado Ophthalmological Society. He was also a member of the Denver Medical Society and the Colorado Medical Society. Surviving, in addition to his wife, are a daughter, Joan Vogan of Sugar Creek, Texas, a son, James I. Van Bergen of Tucson, Arizona, two stepsons, Dr. H. R. Safford III and Thomas H. Safford; a stepdaughter, Dorothy E. Safford; and three grandchildren.

Dennis G. Bradley, M.D., an obstetrician and gynecologist practicing at Swedish Medical Center and Porter Memorial Hospital, died of an apparent heart attack while vacationing in Mexico on March 9, 1981. Dr. Bradley was 35.

Dr. Bradley was a member of the Arapahoe Medical Society and the Colorado Medical Society. He resided in Englewood with his wife, Pamela Sue, two daughters and a son, all of whom survive him.

Dr. Bradley was born January 31, 1946, in Adrian, Michigan. He attended Michigan schools and graduated from the University of Michigan Medical School, moving to Colorado in 1975.

Jay Edward Crill, M.D., of Tim-

nath, was one of the victims of the recent plane crash near Loveland. Dr. Crill, 31, was headed for work at Sheridan County, Wyo., Memorial Hospital. He was a member of a physician team which provides emergency room coverage on weekends.

Dr. Crill was born in Frederick, MD and received his medical education at the Temple University School of Medicine. He interned at Poudre Valley Memorial Hospital in Fort Collins, spent one year as a family practice resident at the University of Colorado Medical Center in Denver, and returned to the Poudre Valley Memorial Hospital as a family practice resident in July, 1979.

Louis Carl Wollenweber, Jr., 54, of 39 Polo Club Circle, Denver, died on February 14, 1981, at his home. Dr. Wollenweber was a member of the Denver Medical Society, the Clear Creek Valley Medical Society and the Colorado Medical Society. Dr. Wollenweber was also a member of the Colorado OB-GYN Society. He was an associate assistant clinical professor at the University of Colorado School of Medicine and was former chief of staff at Lutheran Medical Center. Dr. Wollenweber was born in Denver August 6, 1926, graduated from East High School, the University of Colorado and the University of Colorado School of Medicine. He interned at Buffalo General Hospital, Buffalo, N.Y., and took specialty training at the University of Colorado School of Medicine at Denver. He married Frances Cotton June 15, 1951, in Denver.

Dr. Wollenweber is survived by three daughters, Amy Whalen, Patricia Wollenweber and Cindy Wollenweber, all of Denver, and a son, Louis, of Portland, Oregon.

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Private practice, fee-for-service medicine seems to be in a critical state of balance, dependent upon the many other facets of our medical care delivery system. Physicians are feeling threatened by such things as new marketing efforts by hospitals, both private and public, by industry and business talking of coalitions to cut employee medical costs, of the confusion and, possible threat, of the HMO, of the trends of growing awards in malpractice suits and claims.

Fee-for-service medical practice has been, in the past, the binder which has held this system together; however, there are doubts as to just how key a role this segment still plays. Many of our articles this month are as a direct result of the Component/Specialty Society Officer's Meeting which is to be held on June 26th, wherein these issues will be discussed. *Colorado Medicine* will continue to report on these issues during the coming months, as the COLORADO MEDICAL SOCIETY organizes its efforts to protect this critical balance for its private practice members.

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articles

207 Less Than Effective Drugs:

F. Lee Bowling, M.D., Denver, Colorado

Scientific findings versus legal rights of drug manufacturers have developed into concern for which of these factors would best protect the welfare of the patient. Dr. Bowling reviews findings of the Food and Drug Administration, the National Research Council and the National Academy of Sciences.

208 Questions and Answers:

Regarding the CMS Professional Liability Insurance Trust: a series of questions which has been generated from the meetings held during May and June concerning the new Trust, and the answers from our insurance brokerage firm and the Executive Committee of CMS.

210 Leptospirosis in a Traveler from Honduras:

Frederic J. Pashkow, M.D., Loveland, Colorado, Charles H. Calisher, PhD, Fort Collins, Colorado, Barth Reller, M.D., Denver, and Catherine R. Sulzer, PhD, Atlanta, Georgia.

An extensive list of diseases is developing, from world travelers who, with the speed of sound, are finding themselves in new lands within the incubation periods of these diseases. Jet travel is not all good, when it comes to disease.

213 Preoperative Hematologic and Oncologic Problems:

Martin J. Rubinowitz, M.D., Denver, Colorado. Dr. Rubinowitz is Chief of the Hematology-Oncology Section and Director of Medical Education at the Denver Clinic. He is also Associate Clinical Professor of Medicine, Univ. of Colorado.

This discussion focuses on the special attention needed by patients with hematologic and oncologic diseases undergoing surgical procedures.

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190 Market place affecting practice of medicine

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192 Successes scored in First Annual Health Concerns of Women conference

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The CMS Board doesn't fully agree with the final amount, but recognizes the value of the work done by the CMS Negotiations Committee in reaching these new levels of reimbursement.

194 Advance Program for CMS Annual Session Sept. 8-12, 1981

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president's letter



By this time most of us have either heard, or read a presentation from CMS on the evolving development of a deductible program for your malpractice insurance.

This is through a Trust for the coming year and eventually the appearance of a "captive" Colorado physician owned insurance company by July of 1982.

I hope that each of you under-

stands the implications of such a move, both for the coming policy year as well as those years which follow. To insure that you do understand I would like to highlight those points briefly as noted below.

1. A major characteristic of an insurance company is the bank of money which is collected in the form of a premium, put in the bank to earn and later refunded to the insured in the form of a stable minimum insurance premium.

2. Control of the program is achieved through absolute control of the company in such areas as under-

writing philosophy, claims management policy, risk control and defense of claims.

3. Your premium for the coming year, with or without the CMS Trust deductible will increase ten percent.

I hope you realize this is but a signal of the malpractice climate in this country, in this day and age. Your Colorado captive insurance company cannot insure a level premium, and indeed we would be foolish to offer such. However, if all the investment earnings are retained in the state, and if all the control decisions are made with only Colorado physicians' interest at heart, I think we can have the best possible assurance that we are going to pay the least possible amount for that coverage.

4. We need your participation to make this program workable. We need each Colorado physician to return the Trust participation agreement with his check for \$100, which clearly signifies his participation in the program and understanding of the issues involved.

Please forward your Trust participation agreement and/or your questions to Warren & Sommer at your earliest convenience.

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Frank Bartlett McGlone, M.D., of Denver, was elected President of the American Geriatric Society during the Society's recent annual meeting in Boston.

Dr. McGlone has been very active in the field of geriatrics for the past several years and is nationally recognized in the field of geriatrics. He is presently the Executive Director of the Medical Care and Research Foundation of Denver and practices at the Denver Clinic. Dr. McGlone is a founder of the Denver Clinic and the Medical Care Research Foundation. In accordance with the established goal of the Society, McGlone's main purpose will be to improve education for physicians in geriatric medicine.

McGlone was born in Denver and attended the University of Colorado where he received his bachelor's degree in 1934. He earned his M.D. at the University of Colorado Medical School in 1938. His graduate work was done at the Universities of Colorado and Chicago.

McGlone has practiced medicine in Denver, Colorado for the past 42 years with the exception of six years in the military service. He specializes in gastroenterology, internal medicine and geriatrics.

Dr. McGlone is a member of various medical societies including the American College of Physicians, the American Society of Internal Medicine, the American Society of Gastrointestinal Endoscopy, the Archdiocesan Committee on Aging and the Medical Alumni Association. He is also a long-time member of the Denver and Colorado Medical Societies.

McGlone has also received several awards, including the Medical Care and Research Foundation's Distinguished Service Award (1979), University of Colorado Sports Hall of Fame (1971), the Schindler Award (1970), the Alumni Recognition Award from the University of Colorado (1955) and the American Society of Gastrointestinal Endoscopy Award.

Dr. McGlone has published a large number of articles, mainly dealing with gastroenterology.

to letters
the editor

From Canada

NOTE: Following is a letter to Denver from a private-practice ally in Canada with an up-date (not very promising) on the socialized medicine program. We haven't heard much from Canada since Sen. Ted Kennedy faded from the headlines in 1980.

Editor, COLORADO MEDICINE

It looks like things are really starting to heat up in Canada so far as the physicians are concerned. As predicted, the hospitals are closing wings while there aren't enough beds for patients, the emergency wards can hardly keep up with the demand and we've now reached the stage of long waits for surgery.

As the costs began to soar in the mid-70s the Ontario government started to balk at the doctors' OMA fee schedule. Thus, many of the Ontario physicians began to charge the patients the difference (balance billing). Within the last two months, however, the Federal Health Minister, Monique Begin has called on all provinces to outlaw balance billing or she will cut off federal health funds to the provinces.

That means that the only option now left open to the doctors is to opt out of the system entirely and you can bet the government will plug that loophole as well within the next couple of years. When the doctors opt out, the patients pay the doctor directly and they, not the doctor waits for the cheque from the government insurance health scheme (OHIP).

Seventy or so Ontario physicians have taken this route and have formed the Non-Participating Physicians Association. Our local group is planning to go into action with edu-

cational material for the public, including TV interviews, radio shows, newspaper articles and letters etc.

We didn't make it to Denver to ski this year, but there is a possibility that we may get there within the next few years. If our Prime Minister manages to get his Constitution through here (a blatant blueprint for socialism) you may have a lot of Canadians coming down - and not just to ski.

Physicians Honored By National Medical Society

PHILADELPHIA—The American College of Physicians (ACP) announces the election of 286 new Fellows.

Election to Fellowship in the national medical organization signifies that a physician has been recognized by his colleagues as having attained a high level of scholarship and achievement in internal medicine. Usually, Fellows have authorized articles in medical journals, have presented papers at medical meetings, are involved in the teaching of young doctors and medical students, and have made other notable contributions to the advancement of medical science and practice.

Through rigorous membership requirements, the American College of Physicians works to upgrade the quality of medical care, education and research.

Fellowship in the American College of Physicians entitles physicians to use the initials FACP after their names.

Area physicians elected to Fellowship are James W. Patterson, M.D., Aurora; Paul M. Redstone, M.D., Denver; and Lynn A. James, M.D., Grand Junction.



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Knudsen Award Goes To Paul Kotin, M.D.

Paul Kotin, M.D., of Denver, was awarded the highest honor in the field of occupational medicine, the Knudsen Award, by the American Occupational Medical Association at their 66th annual meeting. Dr. Kotin is Vice President for Health, Safety and Environment at Johns Manville Corporation.

The award was presented to Dr. Kotin for his outstanding contributions to the field of occupational medicine. AOMA is the nation's largest society of physicians who promote the health of workers through clinical practice, research and teaching.

Dr. Kotin's medical career has been primarily in the field of pathology and environmental medicine. He has served with numerous advisory groups to government and industry in the areas of environmental quality, research and health. He has held his present position with Johns-Manville since 1974. Prior to that, he was Vice President for Health Sciences at Temple University, Philadelphia, where he was also Professor of Pathology and Dean of the School of Medicine.

Dr. Kotin received his M.D. degree from the University of Illinois in 1940.

While serving with the Federal Government, Dr. Kotin was awarded both the Superior Service Award and the Distinguished Service Medal by the Department of Health, Education and Welfare. He also held appointments as professor of pathology at Duke University Medical Center and the University of North Carolina Medical Center.

Janet Velazquez Is New President of Colorado Heart Association

Janet Velazquez, R.N., of Denver, was elected President for the Colorado Heart Association at the CHA Annual Board Meeting in Colorado Springs. Velazquez is an instructor of basic sciences at the Community College of Denver.

As President of the Colorado Heart Association, Velazquez will serve as spokeswoman and lead the Heart Association in its fight to reduce premature death and disability from cardiovascular disease.

Condensed Minutes, Board of Directors Meeting May 29, 1981

1. Heard presentation by Robert Lederer, M.D., re activities of the Colorado State Board of Medical Examiners.

2. Received activity report from Student Medical Society (University of Colorado School of Medicine) which requested a) CMS allocation currently used for membership meetings to be utilized to provide speakers for Student Medical Society meetings; b) CMS officers be more visible/available to medical school students; c) CMS explore with medical students what CMS can do for them and what the medical students can do for CMS.

3. The Board disapproved request to send an alternate delegate from Colorado Student Medical Society to Student Business Section Meeting held in conjunction with the AMA meeting.

4. Received an excellent interim report on the first Conference on Health Concerns for women. Preliminary review of the evaluations rated the Conference excellent and/or above average. A majority of participants commented positively on the effect the conference would have on their assumption of responsibility for personal health, thereby fulfilling the objectives of the Planning Committee and the Council on Public Health in putting CMS Priority 7, encouraging patient self-responsibility, into practice. The Conference was funded by admission fees and drug company contributions. The Council will provide recommendations for future conferences based on the Planning Committee's evaluation of the response from speakers, participants and members.

5. Approved policies and procedures for the operation of the CMS program for CME accreditation.

Board also found unacceptable the continuation of financing and management of the Consortium in the same patterns as in the past two and one-half years, i.e., salaries, fringe benefits and indirect costs by the CMS, which has cost approximately \$33,800. A proposal for continuation of Consortium as part of the programming of the CMS will be presented to the Board of Directors prior to December 31, 1981.

6. Approved recommendation that Colorado Medical Society support the mandation of 20 accredited hours of continuing medical education for physician relicensure by the Board of Medical Examiners for a period of three years from June 1, 1981.

7. Approved continuation of per diem for Negotiating Committee members only when they are working for the Negotiating Committee as instructed by the Board of Directors.

Approved appointment of a Medicaid Task Force to present an alternative Medicaid reimbursement system, to include: Noel Sankey, Robert Elliott, Tom Hickman, Ray Painter and W. Gerald Rainer.

8. Received report from Colorado Foundation for Medical Care outlining the changes made in the hospital and nursing home review programs; approval of contract with OCHAMPUS, continued support of CME Consortium through December, 1981; request that members of the CFMC Board, with staff support, be asked to serve on the CMS Building Committee, request that CMS provide a regular report at the CFMC Board meetings.

9. Introduced Mrs. Jerri Fowler, newly-elected President of the Colorado Medical Society Auxiliary. Mrs. Fowler applauded the Women's Health Conference. She reported a check in the amount of \$15,274 was presented to the University of Colorado Health Sciences Center from the AMA/ERF. There appears to be some misunderstandings about the AMA/ERF -- and the Auxiliary will attempt to clarify this in their traveling workshops this year. She also requested all physicians to make their contributions through the Auxiliary for credit through AMA/ERF.

10. Approved endorsement/approval of the Rocky Mountain Cancer Conference with "in kind" contribution.

11. Approved filing an Amicus Curiae Brief with the Supreme Court in support of the broad interpretation of the Physician Immunity Statue which Beth Israel Hospital is seeking to have applied in a case before the Colorado Supreme Court. The Physician Immunity bill was proposed by Colorado Medical Society, and during the legislative process it suffered various amendments which imposed substantial limitations upon the applicability of the legislation. Those limitations are so severe that, if given a strict interpretation, the law will provide a very limited benefit to the medical profession. It is in the best interest of members of the CMS that the interpretation be upheld.

12. Approved recommendations of the Executive Committee: A. Response from The Hartford re 1981/82 renewal proposal (1) 10% premium rise, (2) extension of present five year Master Contract to include policy year June 30, 1981, to June 29, 1982; (3) CMS establish a Trust assuming first

(Continued on Next Page)

\$50,000 indemnity loss; (4) insured have option of membership in Trust or full coverage policy through CMS program; (5) Hartford continue to reserve right to market outside CMA-sponsored program for persons not eligible for CMS program; (6) Premium Credit Plan for policy year June 30, 1981, to June 29, 1982, to include investment credit on basis of 75% of the T-bill market basket. Premium credit will be calculated on premiums retained by Hartford for limits up to \$200,000/\$600,000; (7) Beginning June 20, 1981, Hartford will calculate interest on funds in Premium Credit Plan, 1976 through June 29, 1981, at a rate higher than the current 6%; (8) Hartford is responsible for all claims handling and management; (9) All risk management expense borne by CMS Trust. Final negotiations require definition and additional information re aggregate stop loss coverage quotation, provider of aggregate protection, and Hartford's rights to funds held by the Trust. B. Approved structure of Board of Directors for the Trust and Executive Committee as first-time-only Nominating Committee. C. Approved proposed action timetable.

Approved United Bank of Littleton/Denver as Corporate Trustee for the Colorado Medical Society Professional Liability Insurance Trust.

Highlights of the Meeting Council on Socio-Economics May 27, 1981

Members present: M. Ray Painter, M.D., Chairman
Phillip Nelson, M.D.
Douglas Yakjo, M.D.
Gil Madison, M.D. (Negotiations Liaison)
Wilbur Reimers, M.D.
Frederick A. Lewis, Jr., M.D.
Angela Heaton, M.D.

Highlighting the meeting was:

1. The discussion of the efforts of the State Steering Committee for the Voluntary Effort. Council expressed a vote of confidence for the Voluntary Effort and felt that the leadership of CMS did a good job of coordinating efforts to help the committee develop the policy and public information aspects. The CMS Department of Communications has released the Voluntary Effort policy statement to the media.

2. The Council reviewed a proposed Medicaid Survey for CMS, which is designed to assist the Council on Socio-Economics and the Negotiations Committee in their work with the Department of Social Services, the Health Care Financing Administration, and the Blue Cross and Blue Shield of Colorado. It is the feeling of CMS that statistical information that is accurate and current must be gathered from Colorado physicians. The Council did make some changes in the questions, and a new draft will be presented to the President of CMS before being sent to the membership.

3. Considerable discussion concerning a Colorado Department of Social Services Disclosure Regulation, in that the agency feels the recommended changes would enhance the ability of states to contain Medicaid costs. The regulation would allow the Colorado Bureau of Investigation (CBI) to enter a physician's practice without a warrant and search that office's Medicaid records. There is question as to the legal definition of the term "provider," which the Council's staff adviser does not believe physicians are included in this definition. Council passed a motion objecting to the methods of obtaining the information from the physician and asking the DSS for a clarification of the term, "provider." The Council strongly objects to the interruption of the patient/physician private relationship which would be abused by this type of interference.

4. Dr. Phillip Nelson voiced concerns about the Workmen's Compensation program in Colorado, stating that Workmen's Compensation is a potential future problem, and the physicians should begin to research the program in areas of law, finance and physician involvement. Nelson and CMS staff members will meet with Charles McGrath, Division of Labor, and Milo Harris, attorney for Workmen's Compensation, to discuss possible developing problems.

5. A letter from Peter Samac, Executive Director of the Colorado Foundation for Medical Care (CFMC), was reviewed with respect to the responsibility for monitoring the health planning process. This issue was introduced in light of the CFMC financial reductions. The Council moved that component societies should monitor their local HSAs and that the state society will reassume responsibility, through the Division of Socio-Economics, for the review of the state health planning bodies.

Colorado Chapter ACEP News

The Board of ACEP approved funding to be provided by the Colorado Chapter of ACEP for bench or clinical research in Emergency Medicine. The Board approved approximately \$5,500 for this first year's budget for research dollars. If you are interested in serving on the Committee which will evaluate applications for grants, please forward that information to either Vince Markovchick or to the Colorado Chapter office, 1601 East 19th Avenue, Denver, Colorado 80218. If you have a research project and would like to apply for funding, please review the outline of guidelines and time deadlines which follows.

1. Funds are available as of July 1, 1981, and will continue until June 30, 1982.

2. Deadline for application is September 1st, with decisions of approval or disapproval by October 1st.

3. A subcommittee will review the applications and make recommendations, but the final decision will be made by the full Board of Colorado ACEP.

4. Grant monies are only available to members of Colorado ACEP.

5. Only bench or clinical research in Emergency Medicine including prehospital care and all aspects of Emergency Department operation will be considered.

6. Any subcommittee member submitting a grant application will be disqualified from voting on proposal.

7. Prior approval of human research committee must accompany grant proposals.

8. Grant proposals must include:

- a) Goal of study
- b) Abstract
- c) Method
- d) Itemized budget

9. At close of grant period, all funds expended must be accounted for in an itemized fashion. Any unspent funds must be refunded to Colorado ACEP.

10. No stipends as direct payment of primary researcher(s).

Denver General Hospital has received and \$8,000 grant through the Colorado Department of Health from the Federal Government for a study of pre-hospital trauma which will be carried out over the next twelve months.

K. Mason Howard, M.D., President of the Colorado Medical Society will be invited to the next meeting of the Board of Directors to speak on the current trend in the CMS Trust and Malpractice Plan as well as the Classification rationale for Emergency medicine physicians as Category 11.

Colorado Ophthalmological Society Begins New Year

At the June business meeting the Colorado Ophthalmological Society began its new year with a meeting and dinner dance. A new Executive Committee was chosen and is to be composed of Ted Wills, President-elect; Will Ingalls, treasurer; Hirsh Barmatz, Secretary; and Jim Cerasoli, a recent Past President.

A brunch business meeting will be held in Vail during the summer meeting. The brunch meeting is scheduled for 10:00 a.m., on Sunday, July 5th at the Marriot Mark Resort. The meeting will be followed by the afternoon scientific session. There will be a number of important topics discussed at the meeting, including of meetings by COS, election of officers and a presentation-question and answer session by the Colorado Medical Society on the CMS Trust and Malpractice Plan.

The Colorado Ophthalmological Society can be justly proud of the Corneal Transplant Bill which was introduced by Senator Paul Sandoval of Denver and carried in the House by Representative Greg Rogers, also of Denver. The bill was signed by the Governor and went into law as of July 1, 1981.

WHO/IPH Conference in the Netherlands

The World Health Organization (WHO), in cooperation with the IPH Foundation is organizing the Working Group "On Occupational Hazards in

Hospitals" during the First International Congress for Safety, Health and Wellbeing at Hospitals, October 19-21, 1981, in Hague, Netherlands.

The congress will host a number of coordinated activities; the goal of these, symposia and workshops on one hand, the WHO Working Group on the other hand, will be to obtain relevant and practical information from today's hospital employees.

The aim of the WHO Working Group is to specify the occupational hazards of various categories of professional and other personnel employees in hospitals, and to consider measures to be undertaken to prevent adverse health effects from occupational hazards in hospitals.

Children Learn Alcohol-Addiction Myths Early

Quick! Describe an alcohol addict!

Do you first imagine an unkempt male bum who, by day, panhandles quarters for cheap wine and, by night, collapses in a sodden stupor on a park bench or under a bridge? Perhaps, what comes to mind is a suburban doctor's wife whose frustrating, unfulfilled life is made tolerable only by secret nips at the vodka bottle.

These images are among the many common and pervasive myths about alcohol addiction. As a classroom project recently showed in Tacoma, Washington, children learn the misconceptions and stereotypes early.

Last year a class of fifth and sixth graders studied alcohol addiction. Before they began the unit, their preconceived images and attitudes were measured by assigning them to write and illustrate "The story of a day in the life of an alcohol addict". Many of the classic stereotypes showed up in their work, but so did a few real insights.

Perhaps the most striking similarity among the essays is that very few of their fictitious "typical addicts" had jobs, hobbies or other commitments---all they did all day was follow one drink with another until they either fell into bed or became involved in terrible accidents.

One girl's "Bob", for example, drives to a tavern and "keeps ordering stronger drinks. Then his friend comes and has a few drinks with him, then takes him home to bed."

"Jim," a character created by a young boy, "went home because he felt sick. It was 9:00 o'clock at night so he went to bed."

(Continued on Next Page)

Sometimes the drinker doesn't make it all the way home, but the principle remains the same. "Frank", who went to the tavern because he couldn't sleep, "finally went home and was so drunk that on his way home he stopped at the light post and stayed there all night," one child wrote.

The first image of an addicted drinker, created in the minds of children raised with television, is that of the lamppost-leaning drunk (usually hiccupping his way through "How Dry I Am"). It is this image most children recall first, when asked to describe an alcoholic or an alcohol addict.

The truth is, however, most people whose drinking is out of control do maintain some control over other aspects of their lives, at least in the early stages of their progressive disease. Fewer than 3 per cent of all alcohol addicts are "chronic inebriates," Skid Row types with no motivation beyond the next drink. Many among the remaining 97 per cent hold responsible jobs in every imaginable field; their lives are still in full flower, but the weed of addiction is gradually choking every competing interest.

The particular drinks mentioned by the student writers also point to media influence as a major source of information. Beer, the most advertised form of alcohol, was specified most frequently, sometimes by brand name. Vodka, supposedly popular among secret drinkers because it can't be detected on the breath, was a solid second, followed by whiskey, wine and specific mixed drinks.

Beer's frequent mention indicates that one myth embraced by previous generations is fading among today's youth, who know that beer drinkers can become addicted as easily as hard-liquor drinkers. "Taverns" and "bars", rather than cocktail lounges, are where most of the main characters drank to excess.

One child neatly combined the influence of media and the prevalence of beer when he wrote, "After he had sat down to watch TV he turned the channel and saw a tavern being advertised. He wrote down the address, got his clothes on and rushed out the door. By the time he got there he couldn't wait to get a drink." And, the boy noted, "this was a normal day for Jack."

This unearths another misconception: that alcohol addicts are so weak-willed they can be moved to drink by a single advertisement. Actually, the character of the alcoholic addict is about the same as anyone else's -- it's his body that can't tolerate alcohol.

Like diabetes, alcoholism is a chemical disorder. In fact, for a physically addicted drinker, having alcohol in the bloodstream is a more normal condition than not having it.

Some of the students did, however, hold out hope for treatment and recovery. One girl "went to the alcohol center for help and, from that day on, she

learned what alcohol does to the body and quit drinking." Though this is certainly an oversimplified approach, it is noteworthy because of the phrase "what alcohol does to the body."

The teacher went so far as to say, "The most important thing these students learned during the three weeks they studied alcohol addiction is that it's a progressive physical disease." And that, she added, "is more knowledge gained in three weeks than many adults acquire in a lifetime."

Let Me Tell You About CMS!

The Colorado Medical Society has been serving Colorado physicians since 1871 and, today, gives physicians an unprecedented number of membership services for each dues dollar. The following paragraphs list and explain some of the many services available to physicians who are members of Colorado Medical Society.

At the top of the list, CMS offers its members daily services of a highly qualified association staff. This staff is organized into various department which work with and for the CMS member.

COLORADO MEDICAL SOCIETY PROFESSIONAL LIABILITY INSURANCE TRUST (CMS-PLIT) - In the spring of 1981, CMS developed the Trust to enable CMS member physicians to maintain control of their own professional liability insurance program. During the past ten years the Colorado Medical Society has sanctioned a malpractice insurance program through The Hartford Insurance Company.

In an effort to stabilize premium rates and to accrue profits through fiscal investment programs, the Directors and the House of Delegates authorized this program for CMS members.

Enough has been said, as to the reasons for establishing the Trust, through information packets and state-wide programs concerning the new malpractice insurance program (to date, the Trust has attracted a large percentage of CMS members who are now insured through The Hartford and other programs); however, further support is necessary.

THE SINGLE VOICE OF ORGANIZED MEDICINE IN COLORADO - probably the one most important aspect of Colorado Medical Society's existence is the fact that through this professional body you, the individual physician, can have an effective voice in the destiny of your profession, nationally and locally. Through this single voice you can make your opinions heard (with no fear of being improperly represented) in a professional tone, respected by the majority. Through the Colorado Medical Society you can be assured of a continual working relationship with the American Medical Association, your national federation. You will be well represented in Washington, D. C., just as you are in our own Colorado capitol.

THERE ARE MANY OTHER FACETS OF YOUR CMS, one of which is important to every physician in providing him or her with a professional meeting place. At the present time the Colorado Medical Society is well along with its plans to acquire and build appropriate facilities for just such a central headquarters for CMS. This is a direct member service, because, as you will see in a related report on the Building Project, there are many benefits yet to come for the individual CMS member. The CMS headquarters will be a structure and a facility in which you can take great pride, because it will properly represent your proud profession. It will be there to serve your needs.

WHAT ARE SOME OF THE WORKINGS OF THE CMS MANAGEMENT AND STAFF, in their various divisions and departments? Let me list the major such functions:

LEGAL COUNSEL - representing CMS and advising the Society on legal affairs; assisting component societies and committees whenever he or the Executive Vice President deem the situation necessary of legal counsel; answers questions about medical ethics and, although he is not at liberty to assist physicians personally, he will find an appropriate counsel for a physician if so desired by the physician.

INFORMATION SERVICES (Data Processing) - All membership information is processed through CMS's computer, greatly reducing the expenses and employee time. Members' addresses are quick and easy to update so only the most recent addresses are printed in the Physician's Directory. Selective addressing is available to members who wish a selective mailing list on certain occasions - i.e. taking on a new partner, changing address of office or clinic.

PRINT SHOP - CMS offers members low cost printing for office materials such as envelopes, letterhead, desk pads, etc.; duplicating of a variety of printed materials, mailing services for large mailing projects; distribution of materials to CMS membership and related organizations,

councils, committees, etc.

COMMUNICATIONS DIVISION - the Division of Communications serves the Society, its components and members in internal and public information matters, providing on-going community relations and public service information programs.

This division publishes, monthly, the COLORADO MEDICINE magazine, the official journal of the Society. COLORADO MEDICINE is a news organ as well as a scientific journal, with professional and administrative information valuable to the physician's practice. In coming issues of COLORADO MEDICINE, you will see numerous additional services to you, the individual physician.

A mid-month update called the C/M Scanner, keeps physicians informed on any timely and immediate news, relative to their personal and professional well being.

Yearly, the communications staff publishes a state directory of medical members of CMS. The primary purpose of this directory is for physician referral; however, the Physician's Directory is being developed as a complete medical resource book for physicians and other health care professionals.

The communications division also provides component and specialty societies with communication services in design, layout, graphic art, consultation in printing, design, art work writing and editing, in conjunction with the variety of needs of such offices. In this area, the Communications Division provides consulting, training and production in areas of radio and television broadcasting and in newspaper and magazine publishing.

This division plans and conducts a twice-yearly Component/Specialty Society officer's Meeting for new Component and Specialty Society Officers, to develop and continue communications.

Practice management seminars provide proven guidelines for effective and productive management of the physician's practice. These courses help physicians and interns to retain and gather patients. Other seminars alert physicians to the coming of computers, readying physicians for the day of the computer as it impacts their own practice.

GOVERNMENT AFFAIRS DIVISION - staffs the CMS Council on Legislation. Its Division Director is also the full-time CMS lobbyist. The division is responsible for the development and implementation of the CMS legislative programs of the state, and coordination of federal legislative activity, for CMS. Acting as the CMS lobbyist, the Director represents the Society policy and interests to appropriate legislators and executive branch staff.

Last year this division effectively aided passage of numerous pieces of legislation which

(Continued on Next Page)

will help the physician in his own practice. The physician's legislative needs are fully looked after by this division.

PATIENT/PROFESSIONAL RELATIONS AND MEDICAL SERVICE - staffs the Council on Interprofessional Relations and the Council on Medical Service. This division is the CMS contact for issues regarding para-professional providers, pharmacy, rural health, medical manpower, etc. It also continues to staff the CMS Grievance Committee and acts as the professional liaison with other professional statewide organizations, e.g., the Bar Associations, Nurse's organizations, and many more.

SOCIO-ECONOMICS - supports the Council on Socio-Economics, monitoring and making recommendations concerning issues relating to cost and quality of care. The division also coordinates the Colorado Voluntary Effort Steering Committee, a non-partisan group working to stabilize costs in health care.

The Socio-Ec Division has just recently implemented a physician placement service which is free to all CMS members.

PUBLIC HEALTH AND MEDICAL EDUCATION - staffs the Council on Professional Education and the Council on Public Health, administering and delivering continuing medical education to the public, maintaining liaison with the University of Colorado School of Medicine and seeking to improve the availability of CME in Colorado through administration of the AMA on-site accreditation process.

A new program will be implemented this fall to inform teachers in the public schools to help them teach health subjects. A fact sheet will be placed in the teachers' journal to bring educators up-to-date on current health topics.

A program which is just one year old is known as the "Jail Project," a program (which was funded independently from outside sources during its first ten months existence) to help raise the medical standards of county jails throughout Colorado. The successes of this program in its formative months have been numerous, particularly in helping to avoid litigation concerning the welfare of inmates. The program has been recognized for its worth by the Colorado General Assembly, which chose to fund the continuation of the program for the coming year. The Colorado Medical Society is proud of the fact that it led the way in our state to further improve the medical and health care services provided in these institutions. This program is another facet of continuing medical education, helping in the training of jail administrators and employees to provide quality care within the confines of the jails.

Doctors are educated at community hospitals (mini-universities) in conjunction with CME. Travel time for physicians is reduced; the program helps more hospitals in the state to become accredited for CME; provides many benefits to hospitals and staff members to maintain quality

care and broad accreditation.

SPECIALTY SOCIETY LIAISON - provides direct administrative services to 12 Colorado Specialty Societies including, but not limited to, meeting planning, dues billing, newsletters and general secretarial services.

Specialty Society affairs are complicated by the fact that few of these organizations can maintain full-time staff persons. Through this division, CMS has been able to directly benefit its Specialty members in conducting more effective meetings throughout the state, reducing costs to the individual organizations and participants.

COLORADO CONSORTIUM FOR CONTINUING MEDICAL EDUCATION - the Consortium has been a non-profit, joint enterprise between the Colorado Medical Society and the University of Colorado School of Medicine, for the development and implementation of a program to support continuing medical education.

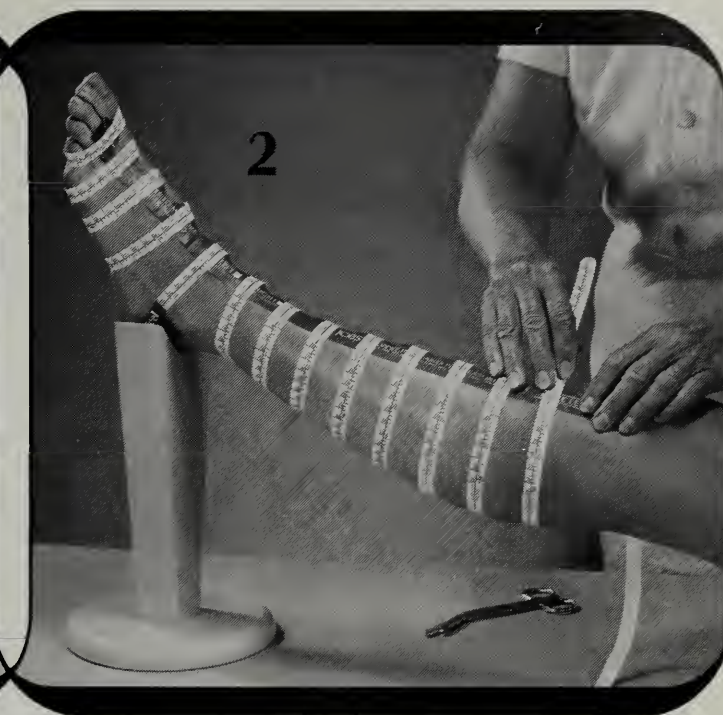
The Consortium 1) assists physicians in Colorado in fulfilling their professional needs and legal requirement of CME by encouraging participation in accredited CME programs, 2) provides assistance, advice and coordination of resources or planners and providers of CME, 3) serves as a clearinghouse and resource center for consumers and providers of CME, and, 4) develops, tests and promotes programs and educational techniques.

Effective in the fall of 1981, the University of Colorado will take the direction of the Consortium on a full-time basis, with the CMS continuing its participation in a variety of ways, none of which will reduce or lessen the importance or effectiveness of this organization.

ADDITIONAL PHYSICIAN SERVICES - A wide variety of individual benefit programs are offered to CMS members, such as health and hospitalization insurance, investment counseling and investment programs, discount programs covering a wide variety of services, such as world-wide auto rental or leasing, equipment purchasing, travel services, individual office and management services, nation-wide collection services with substantial savings in questionable or bad accounts, and a broad variety of communication publishing services. There are more, too numerous to mention here. We urge you to contact your Membership Service office of CMS for more detailed information on any particular program.

THERE ARE MANY, MANY OTHER SERVICES performed by the Colorado Medical Society, each of which has a very direct beneficial effect on your professional practice. If you are not fully aware of what your medical society does for you, or how the society performs these numerous services, contact me and let me, as a non-physician, personally show you the multitude of ways in which CMS, daily, serves you! If you detect an area in which you feel CMS can be of more service to you, I want to hear that, also.

Bill Pierson
Director of Communications



Twin Engineering Devices, to Reduce Massive Lymphedema, and Maintain the Reduction.

Massive and obstinate lymphedema of the limbs may be reduced through use of the Jobst Extremity Pumps (Intermittent Compression) (photo 1). Its controlled pneumatic massage gently removes edema fluid from congested areas.

Jobst Extremity Pumps are available in hospital, clinical, and home models (shown), the latter being available on rental. All units have controls to vary

both pressure and time cycles.

When the desired reduction is attained, it can be maintained with a *Jobst Venous Pressure Gradient*® Support. These supports are custom-made to your prescription and the patient's individual measurements (photo 2). You may prescribe exact counterpressures. "In-Patient" orders will be given special attention.

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2045 Franklin Street
Denver, Colorado 80205
303/861-2007

New Treatment Program Helps Vets Contain War Neurosis

CHICAGO—War veterans gained dramatic relief from the mental tortures of nightmarish reliving of their war experiences through a new drug treatment program reported in an American Medical Association publication.

Traumatic war neurosis may become a chronic, debilitating condition that resists treatment, George L. Hogben, M.D., psychiatrist with Mount Sinai School of Medicine, City University of New York, and the Bronx Veterans Administrative Center, pointed out.

Dr. Hogben reported in *Archives of General Psychiatry* (April) on treating five veterans ranging from World War II through the Korean War to Viet Nam for war neurosis ranging from five to 30 years duration.

All five had been treated with psychotherapy and with medications of various sorts, to no avail. Their mental suffering continued.

The Bronx VA Center began using a drug called phenelzine sulfate, trade name Nardil. There was immediate improvement in all five, he said.

A World War II veteran entered the hospital for severe panic attacks, nightmares, and deteriorating social functioning. He had been ill since the end of the war, and had tried various treatments. Dr. Hogben writes:

"He had extensive World War II combat experience in the European theatre and had infiltrated behind enemy lines. On these missions, he killed many enemy soldiers in hand-to-hand combat. He also saw many of his buddies killed by enemy fire.

"He was captured, and both of his arms were broken by German soldiers. He was hospitalized in a prisoner-of-war hospital in Italy, where he was subjected to many atrocities. German soldiers forced the patient and other sick prisoners into deep, rat-infested pits.

"As the patient's arms recovered, he acted as an orderly in the hospital. He spent hours working with burned and maimed allied soldiers. He was forced to witness German machine-gun executions of many of these patients."

The veteran's nightmares began

shortly after his honorable discharge from service. When not sleeping he heard the voices of his wartime buddies calling out for help. He had panic states with paralyzing fear, sweating, chest pain and stomach upsets. These problems had continued for 30 years.

Within one day after starting a regimen of phenelzine, the patient felt and acted calmer. He gradually recuperated and a year later was functioning moderately well.

A Korean war veteran saw his buddies killed in combat and his position was several times overrun by the enemy. Severe panic with frightening nightmares developed in the field, and he was evacuated to a hospital. Since his discharge, he had avoided elevators and subways and had continuing nightmares of traumatic war scenes. He had turned to heavy drinking to relieve the symptoms when other treatment methods failed.

This man, too, responded quickly to phenelzine.

Two of the others encountered shocking traumatic experiences in Viet Nam, and the fifth man suffered from the trauma of seeing men burned to death in helicopter crashes, even though he was not actually in combat himself.

Each patient felt much calmer almost immediately after treatment with the drug was begun, Dr. Hogben said. The nightmares stopped in all five men and flashbacks ceased in four. Three patients were able to discontinue the drug slowly after three to six months and maintained their improved condition for up to 18 months.

One problem in coping with chronic traumatic war neurosis is that of diagnosis, he said. All of the cases mentioned had been diagnosed for various emotional ailments, most frequently chronic paranoid schizophrenia.

"Chronic traumatic war neurosis is a debilitating condition that prevents many veterans from leading meaningful lives. Many veterans are deeply ashamed of their war experiences and conceal the material from others as well as from themselves."

AMA DRUG EVALUATIONS, FOURTH EDITION, the AMA's manual on drugs for physicians, describes phenelzine sulfate as effective in the

treatment of some depressed patients, particularly those with depressive and phobic neuroses accompanied by anxiety. There is potential for serious side effects, the AMA points out, and patients should be closely supervised and dietary precautions should be observed.

The long-term outcome of traumatic war neurosis treated by phenelzine is uncertain, Dr. Hogben pointed out. Patients who stopped taking the drug against advice showed severe recurrences.

Market Factors Affecting Practice of Medicine

CHICAGO—There is a growing body of evidence that market place forces were operating in the physician services market in the 1970s, and that the trend will increase substantially in the 1980s.

This means that, with the steady increase in numbers of physicians, more doctors are moving into areas that have had few or no doctors for years. And it means that physicians' real income after inflation, taxes and practice expenses showed a decline between 1970 and 1980.

This is the conclusion of a report in the June 5 *Journal of the American Medical Association*.

The June 5 *JAMA* is the annual review of development in health care, *CONTEMPO*.

Writes Harriet S. Myer, M.D., editor of *CONTEMPO*: "If computed tomography was the advance of the decade in the 1970s, monoclonal antibodies are the advance of the year. Their promise in cancer detection, disease therapy and disease research are cited" in the special *JAMA* issue.

The conclusion that the increasing supply of physicians is curbing doctors' earnings and forcing them to seek out small town and rural areas which in the past were considered less desirable practice situations is reached in a report on "The Changing Structure of Medical Group Practice in the United States, 1969 to 1980."

The conclusion is directly opposed to "a widely held but little tested position that physicians, because of their

ability to induce demand for their services to reach a targeted income, are not influenced by economic market pressures," the report declares.

Larry L. Freshnock, PhD, assistant to the division director of the AMA's Center for Health Services Research and Development, and Lynn E. Jensen, PhD, director of the division, present data from AMA surveys made in 1965, 1969, 1975 and 1980 on the growth of group practice in American medicine.

Medical practice groups have grown from 6,371 in 1969 to 10,762 in 1980. Total number of physicians now practicing in groups rose from 40,093 in 1969 to 88,290 in 1980.

The traditional partnership arrangement under which physicians joined their practices for years has given way to the professional corporation. More than 70 percent of the groups are now incorporated.

The data is excerpted from a new AMA book, *Medical Group Practice in the U.S.*, 1980, to be published on September 1.

CONTEMPO also contains survey reports on a wide variety of medical areas, including microsurgery, the laser, computerized radiological scanning, interferon, new drugs, and others.

An important development of the past year is discussed by Robert Veatch, PhD, in an article on medical ethics. It is the adoption of the newly revised AMA Principles of Medical Ethics by the AMA House of Delegates at the 1980 annual meeting. The new principles appear alongside Dr. Veatch's commentary.

The articles are for the most part written by members of the JAMA editorial board, a battery of specialists in all of the many major areas of medicine and surgery.

REDDI Facts

Operation REDDI is a two year, state-wide, public awareness campaign being conducted by the Colorado State Patrol and funded by the Highway Safety Division of the Colorado Department of Highways. REDDI, an acronym for Report Every Drunk Driver Immediately, is the second program in the nation designed to change public attitude from help-less toleration of drinking drivers to

active intervention against their dangerous presence on the roads.

The information campaign will focus on the real victims of drinking drivers. All too often, the community perceives the "victim" as "poor ol' Joe" who received a DUI citation. This often masks the real victims, those who are injured and killed by drunk drivers. To convey this reality, a poster child was located after a review of five years of fatal accidents caused by drunk drivers.

Vanessa Appelhans, an 11-year-old



from Ft. Lupton, was selected as the Operation REDDI poster child. On Christmas night in 1975, Vanessa's Dad was driving his family home to Henderson after Christmas dinner at their Grandparents' home in Brighton. A drunk driver ran a stop sign and slammed into the right front of their car. Vanessa and her father were injured—her mother and three-year-old sister were killed. The drunk driver, whose blood alcohol concentration registered .105 percent, was charged with two counts of vehicular homicide and two counts of vehicular assault. He was found guilty of one count of vehicular homicide, received two years probation and served two weeks in the county jail.

Recognizing that it does not have enough troopers to catch all of the drunks on the road, the patrol is soliciting the public's help. The posters and brochures will also display telephone numbers which citizens can call to report a drunk driver. Following the report, a law enforcement

officer will be dispatched to attempt to follow the vehicle. If he also observes evidence of drunken driving, he will pull the car over and carry out normal procedures for detecting a driver under the influence.

Governor Lamm will introduce the campaign to the public with a press conference in mid-November. The 30,000 posters and 100,000 brochures to be distributed around the state, a television spot and radio spots will reinforce the Governor's message to Report Every Drunk Driver Immediately. Please order your supply of posters and brochures, free of charge, from the Safety and Education Unit at Patrol Headquarters. The telephone number is 757-9412.

After the campaign goes public, there will be weekly press releases reporting the results of field monitoring and featuring other evidences of citizen participation. One full-time Patrol employee has been hired to implement the program with the input of an advisory task force.

This strategy against Colorado's most dangerous drivers was chosen because it is surprisingly effective in Washington State. After only ten weeks of operation, their Patrol received over 2,000 citizen reports resulting in the apprehension of 559 traffic offenders of which 252 were alcohol offenders.

Other effects are also encouraging. Their attitude survey shows that people unsure of their ability to drive are leaving the keys in their pockets and taking cabs home because they don't want to risk being reported. Some of the people who call to report a drunk also testify in court. This program is opening a new channel of communications between the public and law enforcement agencies while also encouraging cooperation between the various law enforcement agencies.

Colorado's drunk drivers may feel that this program pits the rest of the state against them. It does. People who enjoy staying alive will be "REDDI" to stop the drunk drivers before these irresponsible motorists zero in on them—or kill themselves.

ANNUAL SESSION
Keystone, Colorado
September 9-12, 1981

Conference on Health Concerns of Women

Governor Richard Lamm and Lt. Governor Nancy Dick proclaimed Saturday, May 9, WOMEN'S HEALTH DAY, in recognition of the Conference on Health Concerns of Women sponsored by the Colorado Medical Society in cooperation with 11 statewide women's and professional associations.

The day-long conference, held at Thomas Jefferson High School in Denver, was attended by 180 women. Of subjects selected for workshop discussion, *Coping with Changing Roles* proved to be most popular—drawing a total of 120 registrants (one-half of whom attended the morning session; one-half, the afternoon). The remaining workshop's attendance in diminishing order were: *Health in the Middle Years* - 70; *Keep Fit* - 64; *Hormones* - 56; *Women's Rights and Responsibilities as Patients* - 36;

Health in Pregnancy - 8; and *Women, Alcohol and Drugs* - 6. All workshops, save the last two, were presented in two sessions.

A majority of participants commented positively on the effect the conference would have on their assumption of responsibility for personal health, thereby fulfilling the objective of the Planning Committee and the Council on Public Health in putting CMS Priority 7, encouraging patient self-responsibility, into practice.

Members of the CMS and other physicians who contributed their effort included, as Planning Committee members, Drs. Nancy Nelson, chairman; Mabel Brelje; Mildred Doster; Marilyn Trautner; and, as speakers, Drs. Brelje, Trautner, Anthony Angello, Helen Gerash, K. Mason Howard, Mary Jo Jacobs, Frank McGlone, Franklyn Newmark, Janet Schemmel, Eva Sujansky, Frank Traylor, and Janet Weston.



Lt. Gov. Nancy Dick signs the document proclaiming May 9, WOMEN'S HEALTH DAY, in a meeting with health conference sponsors: (left to right) Mary Calhoun-Howe, AAUW; Betty Noris, Colorado Assn. of Hospital Auxiliaries; Loraine Friedman, Fed. of Women's Clubs; K. Mason Howard, M.D., CMS; Ruth Hardiman, Delta Kappa Gamma; Mary Lou Newman, Business & Professional Women.

Physician Placement Directories Published

CHICAGO—Physicians and medical facilities now have help from the American Medical Association in filling their placement needs. The spring quarterly issues of both *Physician Placement Register* and *Opportunity Placement Register* are now available through the AMA's Physicians' Placement Service.

The Registers, one listing available physicians and the other current vac-

ancies, are cross-indexed by medical specialty, type of practice setting, state, and size of community. Also available are separate listings of part-time and *locum tenens* positions and available physicians and a register of overseas opportunities.

The Physicians' Placement Service was established in 1944, and serves as a national resource, crossing both specialty and geographic lines.

There is a one-year registration fee for physicians of \$35.00. AMA members receive a \$10.00 discount. Hos-

Physician's Night At Central City Opera

Medical Friends for Central City - Supporting Central City are sponsoring a Physician's Night at the Central City Opera on August 9, 1981. Puccini's enduring love story "Madame Butterfly" will be performed at 7:30 p.m. after dinner at the Teller House. Dinner starts at 5:30 p.m.

The opera is one of the great cornerstones of 20th century operatic literature, and has been enjoyed by millions since it premiered in 1904. Martha Scheil, a leading soprano with the New York City Opera will be Puccini's strong butterfly Cio-Cio San. The production will be directed and designed by Central City Artistic Director Robert Edward Darling. Randall Behr, remembered for his exceptional work on "The Merry Widow" at Central City in 1979, will conduct.

For more information call: Dr. Ronald Tegtmeier at 424-1174.

pitals and other medical facilities are charged an annual registration fee of \$95.00. To receive a free copy of either Register, write to Physicians' Placement Service, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60610.

Statement on Early Identification of Handicapped Children Approved by Board of Directors

The Board of Directors of the Colorado Medical Society has approved a statement which clearly sets forth the physician's role in the early identification of handicapped children. The statement was drafted by Dr. William K. Frankenberg, Director of the John F. Kennedy Child Development Center in Denver.

In the statement, Dr. Frankenberg notes that Public Law 94-142 requires that school districts assure the early

identification of handicapped children at no cost to parents. But many school districts are hampered in their attempts to comply with this mandate because they lack personnel who are qualified to evaluate such children. A lack of early and repeated contact with the children is also a problem as well as a lack of sufficient funds to provide the service.

Members of the health professions—pediatricians, family physicians, and public health nurses—perceive themselves as being in an ideal position to identify the handicapped child because they have both the expertise and the opportunities to make the evaluations and a knowledge of the children's family history. But in deciding upon whether to turn "child find" over to health professionals exclusively, one needs to review the basic elements of the identification process; namely, screening, diagnosis, and functional assessment.

Through screening procedures, children who are most likely to be handicapped are identified under the direction of the physicians and nurses who deliver the health care. But to keep costs to a minimum, screening tests can be performed by paraprofessionals.

Diagnosis involves the application of tests and examinations to determine the severity of the child's problem. These should be conducted by a physician. But it is frequently necessary for the physician to initiate referrals to allied health professionals or such persons as speech pathologists, psychologists or social workers.

The functional assessment process is required to determine the child's strengths and weaknesses for purposes of planning an effective health program. But the process is most often carried out by allied health professionals and educators.

The statement concludes with this paragraph:

In summary, in order for early identification and intervention programs to be successful it will be necessary for screening, diagnosis and education/treatment efforts to be coordinated by professionals in health and education so that handicapped children will receive the benefits they both need and deserve.

CMS/JBC— Medicaid Financing

The Joint Budget Committee and its peers in the General Assembly have again recognized the physician community in its appeal for equitable Medicaid reimbursement. While the CMS notes that the gains made do not approach true equity in Colorado it also notes that other states (e.g. Massachusetts) have reversed any equitable trends they may have once had.

The Medicaid reimbursement story of recent history can be capsulized by the following numbers:

State fiscal year 1977-1978 initial appropriation for Physician Services

885,535 visits contemplated
\$11.20 unit cost applied

\$9,917,992.00 DOLLARS

State fiscal year 1981-1982 initial appropriation for Physician Services

583,926 visits contemplated
\$28.61 unit cost applied

\$16,706,123.00 DOLLARS

Due to the complexity of federal reimbursement laws (which do not reimburse on the basis of unit cost) it is not possible to identify the exact nature of our gains. However, as demonstrated by the numbers above CMS negotiations may be a shining light for physicians in other parts of the United States.

CMS Seeking Volunteers For Sports Events

The CMS Board of Directors has approved a new program concerning the medical aspects of sports. Primary care physicians and others with sports related specialties are invited to volunteer to take part in the program. Volunteers will be asked to provide medical support services at non-profit sporting events such as athletic play-offs or roadrunning competitions.

Volunteers may also be asked to consult with school athletic programs on the improvement of their sports safety and injury management programs.

ASSISTANCE AVAILABLE FOR THE IMPAIRED PHYSICIAN

Contact:

Physician Health and
Rehabilitation Committee
Colorado Medical Society
1601 East 19th Avenue
Denver, Colorado 80218
861-1221

WATS line: 1-800-332-4150

- For referral of a CMS member who has an alcohol, drug or psychiatric problem
- For help with your own problem
- To offer to assist as a volunteer advocate

The program is designed to provide assistance.

Cancer Immunotherapy: A Realistic Appraisal

A few years ago, there was great hope that new developments in the study of immunology would play a major role in combating cancer. While the level of interest in this area is still quite high, recent investigation has revealed that the human immune system is far more complex than had been previously supposed, and much more research remains to be done. Dr. Charles McKhann, Professor of Surgery and Microbiology at the University of Minnesota Medical School, makes this appraisal in an interview about the current status of cancer immunotherapy and the outlook for immunology research in the future. "There have been disappointments in the application of immunology to cancer," says Dr. McKhann, but while "our progress has not been spectacular, ... research in other areas of immunology has added to the cancer data." Dr. McKhann believes that most researchers in the field are "optimistic that their efforts will result in important contributions to cancer control."

Dr. McKhann also discusses the main defenses of the human immune system, cancer-induced immunosuppression, tumor antigenicity, interferon, monoclonal antibodies, and cancer vaccines. Accompanying the interview are two figures: a diagram of the three major approaches to im-

Due to recent organizational changes the Board of Directors will review all Handbook material including reports and resolutions from Councils and Committees. Therefore, it will be necessary for your Council and Committee reports, to be considered at the 1981 Annual Session, to be given to Iris Thomas and Glenda Chipps by July 14 so they can be duplicated and mailed with the Board agenda for the July 24 meeting.

munotherapy; and a diagram of the interaction between components of the lymphoid system in tumor immunity.

James E. Strain, M.D. Elected To Office

James E. Strain, M.D., FAAP, a pediatrician in Denver, has been elected the next vice president and president-

elect of the American Academy of Pediatrics.

He will take office at the Annual Meeting of the Academy on November 3 in New Orleans.

Dr. Strain is a practicing pediatrician and clinical professor of pediatrics at the University of Colorado School of Medicine. He has practiced pediatrics in Denver since 1950 and has held his present teaching position at the University of Colorado since 1969. Dr. Strain also has served as chairman of the University's Committee on Clinical Faculty Affairs since 1974. He has been a volunteer leader in the Academy since 1967, and is active in local and state medical associations.

Dr. Strain received his degree from the University of Colorado in 1947, interned at Minneapolis General Hospital, and took his residency training at Denver Children's Hospital.

The American Academy of Pediatrics is an organization of 22,000 board-certified pediatricians dedicated to the health, safety and well-being of infants, children and adolescents in North and South America.

Dr. McKinley Retiring Soon

Dr. Joseph G. McKinley, who has practiced medicine in Durango for over 37 years, is retiring and his offices in the Penney Building will be closed April 17. His patients may pick up their records before then to be transferred to another physician.

Dr. and Mrs. McKinley moved to Pagosa Springs in the 1930s where Dr. McKinley practiced medicine until 1944 when he came to Durango to occupy the offices of Dr. Charles Mason and Dr. Fergus Pingrey who were serving in the armed services during World War II.

Dr. McKinley possibly could have the record of delivering the most babies of any doctor in Durango.

CMS Annual Session

Keystone Lodge; September 8-12, 1981

Preliminary Schedule of Events

TUESDAY, SEPT. 8

Tennis & Golf

Evening

Welcome Reception Sponsored by Keystone Lodge

WEDNESDAY, SEPT. 9

Morning

Scientific Program
Medical Executives Group
CMS Finance Committee

Afternoon

Scientific Program
CMS Board of Directors
CMS/CFMC Joint Board of Directors

Evening

Auxiliary President/President-elect Reception
Specialty Presidents' Dinner Meeting
CMS/CFMC Board of Directors Dinner

THURSDAY, SEPT. 10

Morning

Prayer Breakfast
CMS House of Delegates

Auxiliary Board Meeting

Auxiliary Brunch

Reference Committee Chairmen Luncheon

Afternoon

Reference Committee Hearings
Auxiliary General Meeting & Session for County Presidents/Presidents-elect

Evening

President's Reception/Dinner

FRIDAY, SEPT. 11

Morning

COMPAC Breakfast
Auxiliary Workshops
District Caucuses

Afternoon

CMS House of Delegates
Auxiliary Tennis

SATURDAY, SEPT. 12

Morning

CMS Board of Directors Reorganizational Meeting
Medical Assistants Meeting

The 40 day deadline for receipt of resolutions to be considered by the House of Delegates in September is Friday, July 31. A fiscal note will be attached to all resolutions. For assistance in developing the fiscal information, please contact Chris Stein or Susan Clark at the CMS executive office.

Music Therapy Gains Status in Treatment Of Ills

CHICAGO—Music therapy is beginning to gain formal recognition as part of health care for many individuals, especially the elderly, says a report in the May 8 Journal of the American Medical Association.

"It's a blossoming field," says Joe Delle Waller, PhD, assistant professor of music at Catholic University of America, Washington, D.C., where a program leading to a master's degree in music therapy—one of only a few such programs nationwide—has just been instituted.

Dr. Waller says that while music therapy really began to evolve after World War II, "for 20 years, every music therapist was on his own, because no written materials existed to consult for information or creative ideas." She predicts that music therapy will continue to blossom because of the nation's growing population of older persons who need more socialization and mental stimulation.

It may work like this:

The room is full of people and the sounds of a big dance band. The sounds are recorded, and no one is dancing. The elderly persons instead

are sitting in a circle of chairs, passing a scarf around. Whoever is left holding the scarf when the music stops must tell where he is from. This is how music is used to encourage socialization.

In addition, when an older person is having periodic problems with

memory, music therapy may aid by challenging him to distinguish between the sounds of three different musical instruments. Or it can be used in conjunction with physical exercise for stroke victims.

Other groups that can benefit from music therapy, Dr. Waller says, include the mentally retarded, the physically handicapped, the speech and language impaired, and the learning disabled, as well as persons with psychological disorders, delinquent youths, drug abusers, and those having problems with the law.

"Most people will respond to some kind of music," she says, "and it is simply a matter of finding out what kind. In some instances, music is the only kind of stimulation to which someone will respond, because it is a nonthreatening form of communication."

The report appeared in the Medical News section of the Journal.

Grievance of the Month

Editor's Note: the "Grievance of the Month" column was just established in the March issue of Colorado Medicine, and will be appearing monthly as an aid to your private practice. Names, of course, are fictitious, but the circumstances are those reported in grievances handled by your CMS Grievance Committee.

Complaint: Mrs. Upset writes to the Grievance Committee that she feels she has been overcharged for her son's physical examination for football at his high school.

Investigation: The fee for a routine physical examination seemed considerably higher to the members of the Committee than the amount which was generally charged in the community. It also appeared that the physician, Dr. Highguy, had not discussed beforehand with Mrs. Upset what the charges would be. Mrs. Upset had postponed payment, awaiting a decision from the Grievance Committee.

Disposition: It was explained to Mrs. Upset that the Grievance Committee was not a fee-setting organization. However, it was also explained that the Committee can attempt to encourage discussion in a situation such as hers and Dr. Highguy's. Therefore, Dr. Highguy was informed by the Committee of the mother's feelings about the fee; he was encouraged to call Mrs. Upset and discuss the situation with her. He was also encouraged to discuss charges in advance with patients to try to avoid difficulties such as this in the future.

Marbles and Rubber Balls Added to Snoring Cures

CHICAGO—More cures for snoring are listed in the May 1 Journal of the American Medical Association.

It all started some months ago when the Journal published a report from E.L.C. Broomes, M.D., of East Chicago, IN. Dr. Broomes recommended wearing a neck brace collar to curtail snoring. He said that snoring was caused by the chin sagging to the chest, depressing and obstructing the airway, and thus causing the ripping noise of the snore. The collar would hold the chin up and prevent buckling of the airway.

Dr. Broomes' suggestion brought further letters on the subject.

George D. McGeary, M.D., of Bend, OR, recalls a snoring cure originated by his grandmother. It involves sewing a small glass marble into the pajama top between the shoulder blades. When the snorer rolls on his back, the marble digs into the back and the sleeper promptly turns over, usually without waking, or only half waking, Dr. McGeary says.

E. Fritz Schmerl, M.D., of Hayward, CA, points out that sometimes snoring is more than just an annoyance to the others in the family. It might be associated with a condition known as sleep apnea, in which the sufferer

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stops breathing while asleep. This can be a serious medical problem.

Dr. Schmerl's cure is similar to Dr. McGeary's, except he suggests sewing half of a soft sponge rubber ball into the back of the pajamas. Some snorers sew a small cushion or pad, he says.

Thirty-Fifth Annual Rocky Mountain Cancer Conference

Sponsored by: The American Cancer Society, the Colorado Medical Society and the Colorado Society of Osteopathic Medicine.

Place: Sheraton Denver Tech Center, Denver, Colorado

Title: "Controversies in the Management of Breast Cancer"

Registration Deadline: August 1, 1981.

Inquiries: Midge Cullis, The American Cancer Society, Colorado Division, Inc., 1809 E. 18th Avenue, Denver, Colorado 80218.



CME By Conference Telephone

The second Tele-Net Conference sponsored by the Colorado Consortium for took place Friday, May 15, 1981, from Presbyterian Medical Center in Denver. The subject, presented by Sanford D. Peck, M.D., of Presbyterian's Department of Pathology, was "Pitfalls in Anti-Coagulant Monitoring."

The first teleconference in April, "Complications in the Third Trimester", was received by 16 hospitals across the state, from Julesberg to Cortez. About 120 physicians and other health care professionals participated in the conference. For many participants, this was their first CME course taught by teleconference phone.

Evaluations from the first teleconference have been strongly positive. Most of those who responded said they would attend more teleconferences in the future.

Two positive aspects of CME by Conference Telephone are that it makes more accredited continuing medical education accessible to physicians, especially in rural areas. It also allows participants from different areas to compare and exchange comments and experiences with one another.

Physicians who participate in the teleconference series at hospitals that are not CME accredited will receive Category 1 credit through the institutions at which the program originate.

The next teleconference will take place Friday, June 19th at 12:30 p.m. from Montrose Memorial Hospital. The topic will be "Tumor Board at a Community Hospital." "An Old-Fashioned CPC (Clinical-Pathological

Conference)" will be the topic at the fifth teleconference, Saturday, July 18th at 8:30 a.m., from Penrose Hospital in Colorado Springs.

The last teleconference of the series will be "Topics in Emergency Medicine" and will take place Friday, August 21st, at 7:30 a.m. from St. Mary's Hospital in Grand Junction. Hospitals that have not signed up for the entire series may participate in single teleconference presentations at a cost of \$50 per event per hospital.

Council on Professional Education

Highlights of Minutes of Meeting
May 13, 1981

Though the Board of Medical Examiners may withdraw from its authority to require CME hours for physician relicensure, the Council voted unanimously to support mandation for a period of three years beginning June 1, 1981.

Council approved a statement of policies and procedures for the CME accreditation program with minor changes. The statement had previously been approved by the Accreditation Committee and is now ready for review by the Board of Directors. Eventually it will be circulated to all CME Chairman as a manual for the operation of the program.

Council plans to inquire concerning the need for an increase in the accreditation survey fee. It was noted that the fee has not been raised since the establishment of the accreditation program.

Council also reviewed options regarding the future of the Colorado Consortium for CME. A statement of the options is now under consider-

ation by the Board of Managers. Council agreed that additional data and deliberation will be needed before a decision can be made.

Council committee will plan 1981 Annual Session education program. Annual Session Education Day is Wednesday, September 9th.

Dr. Harry Locke announced his departure from Colorado to set up practice in Pennsylvania. He received thanks from Chairman Pat Moran on behalf of the Colorado Medical Society for his long service on the Council.

CME Consortium Arranging Talks For M.D.'s on Alcoholism

The Colorado Consortium for Continuing Medical Education, which is sponsored by the Medical School, the Foundation, and the Medical Society, is contracting with the Department of Health for a program related to alcoholism and drug abuse.

Information on both topics has been developed over the past two years by the Alcoholism and Drug Abuse Committee of the Denver Medical Society. Using this information, the Consortium will offer presentations on these subjects to the medical staffs of six hospitals throughout the state. Faculty for the project will be Stephen Dilts, M.D., a psychiatrist at Denver General Hospital and Thomas Crowley, M.D., Executive Director, Addiction Research and Treatment Center, U.C. School of Medicine.

Dr. Dilts' presentation on alcoholism will emphasize methods of early

HOW TO USE MEDLINE

For computerized literature retrieval, call Martha Burroughs, Denver Medical Society Reference Librarian, on the free WATS in-line, 1-800-332-4150. She will contact the National Library of Medicine computer to request the needed information. Immediate transmission of citations to material published since 1977 will take place, while literature published since 1966 can be obtained in less than a week.

identification of alcoholism in patients, as well as resources in the community to assist persons who are either alcoholics or insipient alcoholics. Dr. Vernon's presentation on drug abuse will emphasize methods of identifying patients who are seeking to obtain inappropriate quantities of drugs from physicians.

These presentations will be offered between now and the end of the calendar year. Continuing Medical Education planners who are interested in such presentations should be in touch with Kevin Bunnell at 861-1221, ext. 262 or 1-800-332-4150, ext. 262.

Committee Renews Accreditations

At the April 20th meeting, the CMS Committee on Accreditation approved full accreditation renewal for five applicants. These were: the Colorado Dermatological Society for four years, the Colorado Psychiatric Society for four years, St. Mary-Corwin Hospital for two years, Swedish/Porter Hospital for four years, and Rose Medical Center for two years.

Reports were presented on possible future accreditations. Three Colorado hospitals are expected to apply for accreditation within the year. They are: Southwest Memorial Hospital in Cortez, La Plata Community Hospital in Durango, and Delta County Memorial Hospital in Delta.

In addition, four hospitals in the San Luis Valley are planning to form a consortium for CME which will probably apply for accreditation also. The San Luis Valley AHEC will provide administrative services.

Aurora Community Hospital has already applied for accreditation, and the Committee approved plans for a site visit.

Also approved by the Committee were two proposed changes in the accreditation policy statement. Approval of the document as a whole was reaffirmed, and the statement will now go to the CMS Board of Directors for their approval. Eventually, the policy statement will be circulated to all accredited hospitals and organizations.

The meeting concluded with a report by Kevin Bunnell on the Teleconference Program sponsored by the Consortium. One of the five scheduled programs has been presented with 16 hospitals partici-

pating. Evaluations of the presentation have been favorable.

Comprehensive Data Systems in Prospect For Doctor's Offices

In five to six years, comprehensive medical data systems comparable to hospital systems will be available to doctors' offices. Many of these systems will be separate from but compatible to the systems in hospitals.

With such systems, doctors will be able to manage the medical data of ambulatory patients and also will be able to manage their hospital patients when appropriate. It will be possible, for example, for a doctor to review the test results of a hospitalized patient and to issue new orders for treatment of the patient.

This innovation in computerized data systems for doctors was a major point made by Kevin Bunnell, director of Continuing Medical Education and Public Health division at CME, in a presentation at Boulder on Colorado Physicians and Telecommunications. This presentation is part of a program on computers and telecommunications made available by the Colorado Consortium for Continuing Medical Education and the Denver Medical Society.

Bunnell and Martha Burroughs, Reference Librarian for DMS, have made the presentations in Montrose, Grand Junction, La Junta, Glenwood Springs, Fort Morgan, and Loveland as well as Boulder.

The presentations consist of free on-line, on-site MEDLINE searches for medical staff plus an overview of the uses of computers and telecommunications in medical settings.

16 Colorado Hospitals Receive CME By Conference Phone

Sixteen hospitals throughout the state are participating in the CME By Conference Phone project developed by a special telecommunications task force with assistance from Elmer Koneman, M.D. The task force, with members from the UCMC, CHA, VA and CMS, developed the project under the sponsorship of the Consortium.

On Friday morning, April 17th, medical staffs of hospitals from Jules-

burg to Cortez participated in a conference on "Complications in the Third Trimester" given by Watson A. Bowes, Jr., M.D. and John G. McFee, M.D. of the UCMC. The long distance teleconference system allowed participants to interact with each other and with Dr. Bowes and Dr. McFee at the UCMC where the program originated. The teleconference project will continue through August, with monthly one-hour conferences originating from different hospitals throughout the state.

"Recent Advances in Diabetes Management" will be presented by George F. Cahill Jr., M.D., Mel Stjernholm, M.D., and Fred Hofeldt, M.D., Saturday, August 29, 1981.

The seminar will be held at Glacier Park Lodge in East Glacier, Montana and it is possible that some physicians may take advantage of this educational opportunity while vacationing. The objective of this seminar is to provide a comprehensive course in new concepts of diabetes management for the practicing physician. Seven to eight Category 1 credits will be offered.

For more information, interested physicians may contact Stanlee Dull, Executive Director American Diabetes Association, Montana Affiliate, Box 2411, Great Falls, Montana 59403 or call: (406) 761-0908.

FACULTY

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Anorexia nervosa and marital therapy are two of the topics selected by the American College of Psychiatrists to inaugurate its monthly ACP-Psychiatric Update audiocassettes. Each hour-long program presents ACP-chosen specialists in a structured yet unrehearsed panel-discussion format centered on a single issue.

Each Update program consists of an audiocassette and a printed transcript of the complete panel discussion. A self-evaluation quiz and statement of learning objectives precede the transcript, and post-test questions, response form, and a supplementary reading list are printed at the end.

The Colorado Psychiatric Society and the Library have jointly purchased the ACP-Psychiatric Update Program for a two-year period. Take advantage of this unique continuing medical education opportunity as soon as Update materials are available on loan from the Library.

MUSCULOSKELETAL SYSTEM

Atlas of Orthopaedic Surgery: Louis A. Goldstein. 2nd ed. St. Louis, Mosby, 1981. 646 p. \$90.00.

Compartment Syndromes: Frederick A. Matsen. NY, Grune & Stratton, 1980. 162 p. \$21.00.

Exercise Physiology: William D. McArdle. Philadelphia, Lea & Febiger, 1981. 508 p. \$17.50.

Low Back Pain: Bernard E. Finneson. 2nd ed. Philadelphia, Lippincott, 1980. \$42.00.

Management of Head Injuries: Bryan Jennett. Philadelphia, Davis, 1981. 361 p. (Contemporary neurology series; v. 20). \$35.00.

Total Knee Replacement: A.A. Savastano. NY, Appleton, Century-Crofts, 1980. 243 p. \$22.50.

PHARMACOLOGY

Casarett and Doull's Toxicology: Louis J. Casarett, ed. 2nd ed. NY, Macmillan, 1980. 778 p.

Guide to Prescription Drug Costs: U.S. Department of Health and Human Services. Washington, D.C., HCFA, 1980. Gift.

Handbook of Emergency Toxicology: Sidney Kaye. 4th ed. Springfield, IL, Thomas, 1980. 565 p. \$54.75

Review of Medical Pharmacology: Frederick H. Meyers and others. 7th ed. Los Altos, CA, Lange, 1980. 747 p. \$17.50.

PATHOLOGY

Cancer Epidemiology in the U.S.A. and U.S.S.R.: Bethesda, MD, National Cancer Institute, 1980. 241 p. Gift.

Malignant Solid Tumors in Children: Wataru W. Sutow. NY, Raven Press, 1980. 228 p. \$20.00.

National Conference on the Care of the Child with Cancer: American Cancer Society. Boston, A.C.S., 1979. 200 p. Gift.

MEDICAL PROFESSION

Law in the Practice of Psychiatry: Seymour Halleck. NY, Plenum, 1980. 294 p. \$21.50.

A National Health Care Strategy: Paul Ellwood and others. Washington, D.C., InterStudy, 1978. 5 v. Gift.

Physician Recruitment and the Hospital: Harry E. Olson, Jr. Chicago, American Hospital Association, 1980. 146 p. Gift.

The Physician's Practice: John M. Eisenberg and others, ed. NY, Wiley, 1980. 274 p. \$18.00.

Physician's Primer on Computers: Jan F. Brandeys. Lexington, MA, Lexington Books, 1979. 178 p. \$17.50.

Working for a Healthier America: Walter J. McNerney, ed. Cambridge, MA, Ballinger, 1980. \$20.00.

PUBLIC HEALTH

Handbook of First Aid and Emergency Care: American Medical Association. NY, Random House, 1980. Gift.

Health Policy: Congressional Quarterly, Inc. Washington, D.C., GPO, 1980. 140 p. \$7.95.

Maxcy-Rosenau Public Health and Preventive Medicine: John M. Last, ed. 11th ed. NY, Appleton, Century, 1980. 1926 p. \$64.50.

Preventing Disease/Promoting Health: U.S. Department of Health and Human Services. Washington, D.C., Dept. of HHS, 1979. 1118 p. Gift.

Public Health and Community Medicine for Allied Medical Professions: Lloyd E. Burton. Baltimore, Williams & Wilkins, 1980. 599 p. \$29.95.

PRACTICE OF MEDICINE

Current Medical Diagnosis and Treatment: M.A. Krupp and M.J. Chatton. Los Altos, CA, Lange, 1981. 1100 p. \$21.00.

The Diagnosis of Stupor and Coma: Fred Plum. 3rd ed. Philadelphia, Davis, 1980. 373 p. (Contemporary neurology series; 19). \$22.00.

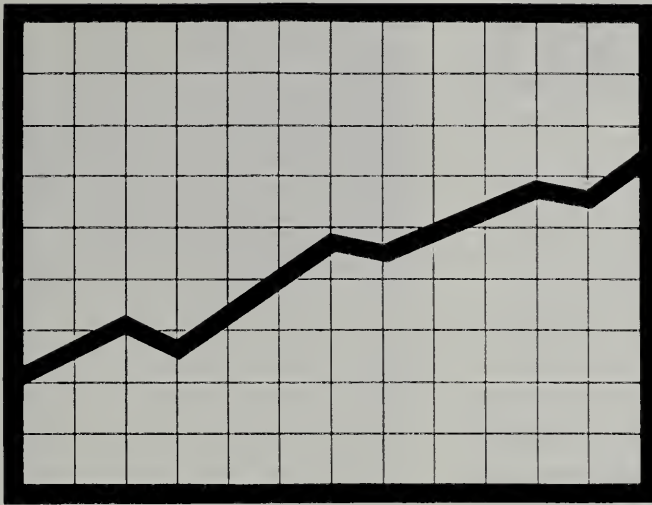
Prognosis: James F. Fries. Bowie, MD, Charles Press, 1981. 565 p. \$34.95.

HEMIC AND LYMPHATIC SYSTEMS

Blood Cells and Vessel Walls: Ciba Foundation. NY, Excerpta Medica, 1980. 357 p. (Ciba Foundation Symposium, 71) Gift.

Hodgkin's Disease: Henry S. Kaplan. 2nd ed. Cambridge, MA, Harvard University Press, 1980. 689 p. \$50.00.

(Continued on page 223.)



MALPRACTICE AWARDS KEEP CLIMBING!

Colorado Physicians Form Insurance Trust
To Combat Ever Increasing
Insurance Costs!

June 1981 marks the beginning of the Colorado Medical Society Professional Liability Insurance Trust (CMS - PLIT)!

After months of negotiations with The Hartford Insurance Company, the CMS Executive Committee came to the unanimous decision that the only way to combat the rising costs of ever-increasing malpractice awards, and the continuing threat of frivolous suits against physicians was to work toward self insurance. **That is what is happening!**

The CMS Professional Liability Insurance Trust is the first major step toward a Physician-Owned Captive Insurance Company.

**YOU NEED THE TRUST!
THE TRUST NEEDS YOU!**

Call today! Get full details on what the CMS-PLIT means to you! If you have not received the Professional Liability Insurance Trust Program details (an information packet was sent each member in early May), call the CMS office at 861-1221 or (WATS line) 1-800-332-4150!

Every Colorado physician needs the Trust!

The Trust needs the participation of every Colorado physician!

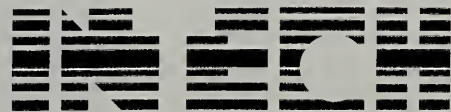
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The Intech/Micromed Medical Management System is so good, you'll probably think it doesn't cost enough. Compare capabilities, flexibility, speed. Compare warranties. Then compare price. If you thought only costly mini-computers or inflexible timesharing services could cure your office headaches, think again. Our system includes the latest version of MicroMed™, the software that has helped over one thousand individual and group practices and clinics to become more profitable and efficient. Call us. You'll get more than your money's worth.

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- **Automated form letters and mailing lists**
- **Appoint Recall**
Prints reminders and appointment lists
- **Daily Reports**
 - Charges and receipts—daily activity report
 - New accounts list
 - Doctor/producer reports
- **Monthly Reports**
 - Delinquent accounts report
 - Aged accounts relievable
 - Insurance billing
 - Regular billing
- **Special Reports**
 - Productivity/profitability analysis
 - Unpaid treatments list
 - Custom reports generator
- **Word Processing**
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(303) 421-0920

The Consumer Price Index Revisited

On May 19, 1981, Mr. Elliott Brower, Regional Commissioner of the U.S. Bureau of Labor Statistics, Kansas City, Missouri, appeared before the Colorado Medical Society to explain what the Consumer Price Index (CPI) means to physicians. CMS believes this visit was the first of its kind (specifically addressing physicians and physician relation to the CPI) in the nation. We thank Mr. Brower for his willingness to discuss the issues.

Mr. Brower pointed out that the CPI is not a pure reflection of inflation. He indicated that the CPI began in the early 1900s as a tool of the labor unions to negotiate wage increases for their members. Later, the CPI's data collection and market basket analysis improved. Then, Congress began indexing legislative programs to the rise and fall of the CPI. When this legal institutionalization occurred, the public was led to believe that the CPI was a total reflection of inflationary elements. You, the physician, may see a CPI index clause in your medical office lease. Such a clause is a demonstration of this unintended use of the CPI.

Mr. Brower instructed that the CPI measures a "market basket" of goods. (The "market basket" is measured at retail, not wholesale, prices.) However, this measurement EXCLUDES one-third of our national economy (e.g., life insurance, income tax, social security payments, and charitable gifts and contributions).

Major items which make up the "market basket" are given relative weights each year, to reflect their importance in the data accumulation.

Mr. Brower explained that medical care is a major item in the index. In December, 1980, medical care was given a relative weight of 4.717. Physician's services constitute a component of the medical care item. The physician's services relative weight for the same period is 1.877.

It is clear, then, that the cost of physician's services has very little to do with an overall rise in the CPI. Housing (45.5), transportation (19.0), and food (18.3) are the items which provide for significant drives in the CPI.

It is important to know which CPI in

the news relates to you. There is an index for wage earners and clerical workers (CPI-W). There is also a CPI for all urban consumers (CPI-U).

Similarly, you should understand that national CPI data is collected from Denver and Colorado Springs, but the data received is statistically valid for national purposes, ONLY! It has little relevance for Colorado, itself. Included here is a chart, with figures supplied by the Bureau of Labor Statistics, showing the composition of the medical care component of the consumer price index for all urban consumers, and the relative importance of major items. Statistically, the CPI uses a base year, 1967 (which will soon be changed to 1977).

As an aside to Mr. Brower's comments about the CPI, it is very interesting to note that the inflation rate in 1946 was 18.2% (worse, much worse, than 1981), and in the 1950s it dropped to a yearly rate of 2.1%. In the 1960s the inflation rate was 2.5%. In the period, 1965 through 1969, the yearly inflation rate rose from 1.7% to 5.4%, representing a 300% increase. In the 1970s the inflationary rate was 7.1%, while 1975 through 1979 grew



Mr. Elliott Brower, Regional Commissioner of the U.S. Bureau of Labor Statistics, Kansas City, Missouri, addressed physician-members and staff of the Colorado Medical Society with explanation of the "meaning of the CPI." Brower made it clear that the cost of physician's services has little to do with the overall rise in the CPI.



from 5.0% to 13.5%.

If you compare the 1965 to 1969 period with the 1975 to 1979 period, the latter period seemed to have more severe inflation, while statistically, the rate of overall increase was 300%, 1965 through 1969, and only 150%, 1975 through 1979.

The current rate of inflation, year to date, with seasonal adjustment, is 10%.

Robert FitzGerald, Director
Division of Socio-Economics
Colorado Medical Society

Workmen's Compensation Conversion Factors

The Colorado Industrial Commission has promulgated new conversion factors to be used when you bill a workmen's compensation insurer. The factors are:

Medicine—\$4.60
Anesthesia—\$12.75
Surgery—\$44.60
Radiology/Nuclear—\$10.90
Pathology—\$11.55
Testimony (½ hour)—\$100.00

In addition the Commissioners will proceed with a study of the Relative Value Schedule as currently adopted.

A Mini Lecture On Collections

Many physicians have asked the CMS for a concise statement of the "Do's and Don'ts" of the collection process. The information below is intended to simplify your practice.

RECOMMENDATIONS

DO:

- Attempt to advise patients "up front" of their payment responsibilities, including a statement of your fees, whenever possible;
- Develop reasonable office procedures designed to give the patient notice of overdue bills;
- Age your accounts for an analysis of patients who have legitimate problems or those who are malingers;
- Find out whether your collection agency complies with Colorado law (license, bond, trust accounts).

DO NOT:

- Hold yourself out to be a collection agency;
- Threaten to use a collection agency unless your intent is to use one;
- Speak to third-parties about your patient's debt;
- Speak or otherwise communicate with the patient debtor at unusual times or places;
- Contact the debtor's employer except to confirm the location of the debtor if it is unknown;
- Contact the debtor if you receive notice from the debtor or his attorney that the debtor does not wish to be contacted; except to notify the debtor that remedies specific to the collection process will be pursued (garnishment, attachment, etc.)
- Threaten violence;
- Use obscene or profane language;
- Publish a list of debtors;
- Advertise for sale any debt to coerce payment of the debt;
- Use the telephone with the intent to annoy or harass;
- Use deceptive means for purposes of collection (I'm here for the XYZ charity)
- Collect any amount unless it was expressly authorized by a written agreement which creates the debt;
- Communicate with a debtor by postcard.

Finally, use your common sense. How would you wish to be treated? The decade of the 80's promises stiff competition for patients. Do not lose them needlessly.

| | UNITED STATES | |
|--------------------------------------------------------------------------|---------------|---------------|
| | DECEMBER 1977 | DECEMBER 1980 |
| MEDICAL CARE | 4.969 | 4.717 |
| MEDICAL CARE COMMODITIES | 0.859 | 0.785 |
| PRESSCRIPTION DRUGS | 0.391 | 0.359 |
| Anti-infectious drugs | — | — |
| Tranquilizers and sedatives | — | — |
| Circulatories and diuretics | — | — |
| Hormones, diabetic drugs, biologicals, and prescription medical supplies | — | — |
| Pain and symptom control drugs | — | — |
| Supplements, cough and cold preparations, and respiratory agents | — | — |
| NONPRESCRIPTION DRUGS & MEDICAL SUPPLIES | 0.468 | 0.426 |
| Eyeglasses | — | — |
| Internal and respiratory over-the-counter drugs | — | — |
| Nonprescription medical equipment and supplies | — | — |
| MEDICAL CARE SERVICES | 4.111 | 3.933 |
| PROFESSIONAL SERVICES | 2.008 | 1.877 |
| Physician's services | — | — |
| Dental services | — | — |
| Other professional services | — | — |
| OTHER MEDICAL CARE SERVICES | 2.103 | 2.045 |
| Hospital and other medical services | — | — |
| Hospital room | — | — |
| Other hospital and medical care services | — | — |

"The Physician's Role in Prescription Drug Abuse" was the title of a membership meeting presentation in April at the Denver Medical Society with speakers including Dale Tooley, Denver District Attorney, and representatives from the Colorado Department of Health, Colorado Board of Medical Examiners, Colorado Board of Pharmacy, Drug Enforcement Administration of the U.S. Department of Justice and the University of Colorado Health Sciences Center.

Doctors were warned about how they inadvertently could assist in

making drugs available on the streets, where a four milligram Dilaudid pill will sell for \$30.00 these days.

Two precautions given were to keep prescription pads in your pockets, never just lying on desks or available on shelves in examining rooms, and carefully writing out quantities such as "one" and "ten" rather than figures where "1" can easily be changed to "10" or where "10" can easily be changed to "100".

Doctors were also urged to stand their ground if they feel they should prescribe a small amount of pills even

though the patient insists that he can get a better price at the pharmacy if the physician prescribed them in 100s.

According to one speaker, more "legitimate" cocaine is prescribed in Colorado than in any other of the 50 states.

The Colorado Consortium for Continuing Medical Education and a special Telecommunications Task Force sponsor **TELE-NET**.

TELE-NET offers:

- Direct, two-way participation in CME programs via a long-distance, conference-style communications system.
- 1 hour of AMA Category 1 credit for each **TELE-NET** presentation attended between April 1981 and August 1981.
- Convenient, relevant CME at low cost.

Your hospital may already be a **TELE-NET** receiver, or may become a receiver at very low cost.

Ask your Director of Medical Education or Administrator to contact the CCCME about this special opportunity. Call or write:

Kevin P. Bunnell, Ed. D., Executive Director
Colorado Consortium for Continuing Medical Education
1601 E. 19th Avenue, Denver, Colorado 80218
(303) 861-1221 (Outside the Denver Metro area dial 1-800-332-4150)

More than 60 physicians from Arapahoe Medical Society and the Denver Medical Society exchanged program and planning ideas recently when members of the 50-person AMS Board of Directors and members of the smaller DMS Board plus members of the three DMS Commissions on Internal Affairs, Public Health and Health Care Delivery got together for a dinner meeting to see if there were ways in which the two societies might work more closely.

Presentations were made by officers and leaders of both societies to acquaint each other with areas of particular concern to each group. Tables of organization and committee lists were exchanged as well as reports and publications in areas such as long-range planning, medical-legal guidelines for civil litigation, mental health and the practice characteristics of selected Colorado health care professionals.

Officers of the two societies will consider establishing a schedule for future similar joint meetings.

Less Than Effective Drugs:

Scientific Finds Support Non-Payment Plans and Malpractice Suits

F. Lee Bowling, R.Ph., M.D., M.P.H., Englewood, Colorado

The most current list of drugs classified as "lacking adequate evidence of effectiveness" was sent to health care providers from the Food and Drug Administration in March, 1981. This classification, and previous ones, are based upon the scientific findings of the National Academy of Sciences-National Research Council. (Copies of the list may be obtained from Colorado Medical Society.)

NAS is a private organization of scientists dedicated to the furtherance of sciences and its use for the general welfare. Members are elected in recognition of their distinguished and continuing achievements in original matters of science and technology. NRC was formed by NAS to facilitate the participation of a broader representation of scientists and technologies in carrying out its objectives.

NAS-NRC evaluations provide degrees of scientific and unbiased significance and credibility that are unequaled.

The Federal Register of June 5, 1980, Department of Human Services, proposed regulations entitled "Medicare and Medicaid Programs; Prohibition Against Payment for Less Than Effective Drugs." Selected quotes from the Federal Register:

1. Drugs affected. Three categories of drugs are affected by this proposal. The first category includes those drugs, previously approved by the FDA, that determination that they are less than effective for all indications and has withdrawn its approval for marketing. We believe that this proposal would lessen, for both Medicare and Medicaid beneficiaries, the risk of taking drugs that may unnecessarily delay med-

ically appropriate therapy and result in possible harm. We do not believe that Federal Funds should be used to pay for drugs that have been determined, after an extensive review and reconsideration process, to be less than effective. The second category includes so-called "me-too" drugs that are marketed under different names or by different firms, without FDA approval...The third category includes drugs, such as Laetrile, that are subject to premarket approval, but have been introduced onto the market without seeking FDA approval...2. Point of termination of Federal reimbursement—...it should be noted that, under our proposal, we would not reimburse for the affected drugs during any appeal or court stay of FDA's final ruling. We believe to do so would represent unnecessary risks to individuals...

In 1970, the Surgeon General implemented a policy prohibiting the use of federal funds in Public Health Service programs for drug products still on the market, but classified as "less than effective" by the Bureau of Drugs, unless no alternative means of therapy exists. The General Accounting Office and FDA have recommended that Health and Human Services issue regulations to expand this policy to Medicare and Medicaid programs, based on the fact that some drugs initially classified by the Bureau of Drugs as "less than effective" still remain on the market.

The proposed regulation would permit continued federal reimbursement under Medicare and Medicaid for a questioned drug until the administrative record is com-

plete and the Commissioner makes a final agency decision that the drug has not been determined to be effective. The policy underlying this proposed regulation respects the exercise of professional judgment by those responsible for the care of patients. The Department assumes a measure of this responsibility through many of its own PHS programs.

The American Medical News of March 13, 1981, reviews the subject of the FDA letter mailed to physicians. This article also states that AMA supported eliminating ineffective drugs once all appeals were exhausted and a final determination was made. In a letter to the Health Care Financing Administration last year, AMA supported a proposed HCFA policy of not paying claims for ineffective drugs. Lawsuits against the FDA for delays in the process of determining effectiveness and settlement terms are also mentioned. These suits originated with the American Public Health Association and the Council of Senior Citizens.

In 1979, the CMS Committee on Pharmacy was approached by the Colorado Pharmacal Association and the Department of Social Services for suggestions on cutting Medicaid prescription costs. The Committee favored elimination of drugs deemed ineffective. This action was conveyed to the Colorado Medical Society House of Delegates at the 1979 Annual Session and approved.

Plaintiff's attorneys in some parts of the country are reportedly including in their malpractice suits the subject of less than effective drugs, based upon the findings of NAS-NRC. The

(Continued on page 209.)

Questions and Answers:

Editor's Note: In late April and early May, the Colorado Medical Society began a campaign to convert the CMS-sponsored professional liability insurance program from a totally commercially administered program to a doctor-owned insurance trust. The plan is to operate through a one-year transitional period in the form of a trust, while moving toward a physician-owned captive malpractice insurance company. The initial steps have been taken, and the program is moving along very well and being favorably received.

During the past month and a half there have been many questions asked about the program. Due to space limitations only the most important questions are answered here. Please feel free to call the staff at the Colorado Medical Society if you have any more questions.

The following are the questions and answers to the important issues concerning the CMS Trust/Captive:

Q. As an obstetrician, I'm liable for the next 20 years even if I retire today. Will I continue to be covered under either the Hartford plan or the CMS Professional Liability Trust plan?

A. You have been paying for occurrence insurance—that covers forever. Our best guess is we will always offer occurrence insurance. ("Claims made" puts all the control on the rate making.)

Q. How many physicians are there in Colorado? You mention 3,600 with Hartford; some aren't with CMS but are with Empire and others. If we do a good job of selling, are these numbers going to get better if we bring people in who are good risks?

A. Currently, there are 3,600 insured in the CMS/Hartford sponsored

plan. There are nearly 4,700 physicians in CMS—500 or 600 others in the state. The optimal situation would be to get every physician currently insured with Hartford's plan to switch over to the Trust. Ideally we would like all physicians in the state to join the CMS program.

Q. Will the upper limits of coverage with the new Trust be the same as with Hartford?

A. The same limits will be available up to \$5 million. Currently, almost 85% have limits at, or in excess of \$1 million.

"...the expertise of physicians with regard to insurance matters is limited."

Q. Capital and surplus needs for the 1982 CMS Captive—is this an extra expense to the physician? Will we be required to put out more dollars for the Captive in addition to our premium?

A. The CMS Captive will require capital. CMS will encourage you to contribute. J. Richard Barnes, Colorado State Insurance Commissioner, thinks a 2 to 1 capital to surplus is appropriate for the Captive. That means in this policy year we will need \$4.5 million in the bank before we sell the first policy.

(a) CMS will save approximately \$1 million just by administering the Trust. This is money that otherwise would have gone to Hartford.

(b) CMS is presently considering

the feasibility of asking physicians to assign their Premium Credit Plan over to the Trust. This may bring in another \$1.5 million the first year and \$2.5 million the following year.

(c) Then, if the 2 to 1 capital to surplus is not large enough the difference between that and the total of (a) and (b) above would be required.

This may require a fund drive.

Q. In running the CMS Trust, it seems there are several areas, i.e., broker's commission, risk management, administration, non-allocated claims, etc. Do you think you could run the program for less than \$2 million with additional savings?

A. Potential dollar savings in expense load is an almost immediate 10% savings from the existing 24.9% expense. The other 14% includes necessary activities for functions of the company. These activities can be less expensive if run by CMS.

Q. How many other doctor-owned companies are there, and has any failed?

A. There are 27 other state or component society owned companies. None has failed. New York has problems. On the other hand, Ohio State Medical Society has been in the captive insurance business 5½ years, kept level premiums 3½ years (they are recommending a 15% premium increase this year). They have developed a bank account of \$17 million excess surplus. The real test may come in the next two years; the market seems to be getting hard again.

Q. CMS Presidents come and go. Where is the continuity of control? How will that be established? How will you assure that someone will be in this position who has the interest

Regarding the CMS Professional Liability Insurance Trust

and knowledge to run a program like this responsibility?

A. There will be three controls. (1) The Board of the Trust/Captive company is chosen by the Board of Directors of CMS. (2) CMS owns that company and hires the insurance professionals in it. The company is run by insurance professionals, and not by physicians. (3) CMS plans to make up the initial Board of the Colorado Captive from the five or six doctors currently serving as the CMS Executive Committee, and who have become most expert. This will assure understanding in

"CMS Presidents come and go..."

running the Trust/Captive. CMS will then bring new members in, and educate them over time. Control comes with the Board being appointed by the State Medical Society; company owned by the State Medical Society, etc.

Q. Will control reside in the staff of CMS because the expertise of physicians with regard to insurance matters is limited?

A. Control will not reside in the staff of CMS. It is not envisioned that the president of the CMS would become the president of the CMS insurance company. The present concept is there will be a physician chairman on the Board of the CMS Insurance Captive to provide continuity. The President of the insurance company will sit on the Board of the CMS Insurance Captive.

Q. Administration. How many people are going to compose that board? Are they going to be salaried?

A. The Board will be composed of eleven people. Five of them will be physicians and six of them will be laymen. Two of the physicians will serve as Chairman and Vice Chairman. One layman will be the Chief Executive Officer of the Captive. One layman will be the Executive Vice President of the Colorado Medical Society. It is highly unlikely that any members of the Board will be salaried. The staff of the insurance company obviously will be salaried.

Q. Are these Board members to be elected or nominated by the House of Delegates? Will they be area designated or just anybody who wants to run for that board?

A. The Board of Directors of the Colorado Medical Society will be the nominating committee as this time. It is presumed that from the first the Board will be compiled of people knowledgeable about malpractice in Colorado and that they will have business experience.

Q. Who are you going to buy stop-loss insurance from?

A. Probably Hartford.

Q. Is Hartford going to write policy for only one year?

A. CMS has negotiated a one year extension of the current five year contract. Renewals in the future will be, as in the past, for one year at a time.

Q. Must I be a member of CMS to participate in this program?

A. Yes!

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Less Than Effective Drugs:

(Continued from page 207.)

details and the scope of this development are not known at this time. As of May 4, 1981, various Washington sources have provided the following input:

The Federal Register of June 5, 1980, remains current. Final action is anticipated within a couple of months. A final FDA decision to eliminate these drugs from the market would also eliminate the need to implement the proposed Medicare and Medicaid regulation. This procedure would be compatible with the present trend in Washington, D.C., to reduce the number of regulations.

The very few manufacturers that have gone to court to protest a drug's classification as ineffective have, in most part, contested procedure rather than the substantive findings of NAS-NRC. FDA has reversed the classification in very few instances based upon additional scientific evidence supplied by manufacturers. Communications (on drugs classified as lacking evidence of effectiveness) to health providers are not necessarily mailed to each individual, but through agencies and other central points. This could explain why many physicians in Colorado have been unaware of these documents. In October, 1980, a mini-survey revealed that CMS physicians in the practice of internal medicine, pediatrics, orthopedics, psychiatry, ob-gyn, aerospace medicine, and occupational medicine had not been receiving the information.

Issues for evaluation are the scientific findings versus legal rights of manufacturers to challenge these findings and the desire of some physicians to continue prescribing. Which of these factors most objectively insures the welfare of the patient and protects the prescribing acumen of the physician? How many manufacturers of less than effective drugs would come to the financial rescue of a physician charged in a malpractice suit with prescribing these drugs?

Leptospirosis in a Traveler from Honduras

Frederic J. Pashkow, MD, Loveland, Colorado; Charles H. Calisher, PhD, Fort Collins, Colorado; L. Barth Reller, MD, Denver, Colorado; and Catherine R. Sulzer, PhD, Atlanta, Georgia*

Twentieth century travel, with its almost instant shifting of individuals, has allowed arrivals in new lands within the incubation periods of an extensive list of diseases. A case report of a case of leptospirosis from Honduras is considered.

Jet airliners enable rapid international travel for business and pleasure, well within the incubation period of many exotic infectious diseases. Travelers have returned to the United States with febrile illnesses caused by a variety of agents including viruses (dengue from Nigeria via the Caribbean,¹ Japanese encephalitis from Japan [C.H. Calisher, unpublished data], tick-borne encephalitis from Hungary,² Venezuelan encephalitis from Mexico,³ Lassa fever from Sierra Leone,⁴ smallpox from Korea,⁵ and Ross River fever from Fiji [C.H. Calisher, unpublished data]); bacteria (typhoid fever from Mexico, India, and elsewhere)⁶; and parasites (malaria from Africa, India, and Latin America)⁷.

We report here a case of leptospirosis, with fever and aseptic meningitis, in a traveler from Honduras.

CASE REPORT

A previously healthy 37-year-old married woman was admitted to McKee Hospital in Loveland, Colorado, on December 24, 1978, because of a high fever. Her illness began with a dry cough and stiffness and pain in her neck on December 19, 2 days after arriving in the United States from Honduras, where she had lived for the previous 8 months. Over the next 24 hours, her myalgias and arthralgias became severe; she was prostrate with overwhelming malaise, headache, and an oral temperature of 39.4°C. On the eve-

ning she entered the hospital she was nauseated and vomited; she had no diarrhea.

The patient had traveled extensively abroad and had lived in Southeast Asia and other areas of the Far East. While in Honduras, she had not taken chemoprophylaxis for malaria and had not been vaccinated against yellow fever. She was aware that dengue was present in Honduras in the summer of 1978 and recalled a similar illness in her husband and 2-year-old child during that stay. Patient further related that on frequent occasions she and her family spent weekends at a beach house, had found rodent excreta on kitchen shelving there and had, in fact, seen "rats" several times while there. She did visit rural areas of Honduras.

Physical examination showed an acutely ill woman whose face and neck were flushed. Her oral temperature was 39.2°C; the blood pressure was 120/80 mmHg, with pulse and respiratory rates of 120 and 16-18 per minute, respectively. The pharynx was normal, but the submandibular and anterior cervical lymph nodes were tender and slightly enlarged. Despite muscle soreness, the neck was supple. There was diffuse tenderness and some deep guarding on palpation of the abdomen; the liver and spleen were not enlarged. There were no petechiae. The remainder of the physical examination was normal.

The initial hemogram showed a hematocrit of 38%; hemoglobin of 14 g per dl; and white blood cell (WBC) count of 7,500 per ul with 52% mature neutrophils, 38% juvenile forms, 6% lymphocytes, and 4% monocytes. The urine was a hazy yellow with a specific gravity of 1.019, pH of 5, 2-plus protein, urobilinogen of 4 Ehrlich units (normal up to 1 unit), and 40-50 WBCs per high-powered field in the sediment. Tests of liver function showed alkaline phosphatase, 8.9 IU/dl (normal=2.5-9.7 IU/dl); bilirubin, 0.8 mg per dl (normal=0-1.5 mg/dl); and transaminases, S.G.O.T. 60 IU/L (normal=8-33 IU/L) and S.G.P.T. 25 IU/L (normal=3-36 IU/L) per ml. A total of six sets of blood cultures were negative as were morning, afternoon, and evening thick and thin blood films for malaria. No parasites and no occult blood were found in the feces. The chest radiograph was normal.

The patient's hospital course was as follows: Because she remained febrile with a temperature spike each day, she was treated with a standard course of 2.5 g of chloroquine over 3 days to avoid the possible com-

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plications of falciparum malaria. On December 26, 1978, her 7th day of illness, she became afebrile and felt much better, except for a persistent headache. Two days later she awakened with a severe headache, myalgias, and a stiff neck. A lumbar puncture was done. The cerebrospinal fluid (CSF) showed WBCs, 30 per ul, with 23 lymphocytes and 7 neutrophils; glucose, 39 mg per dl, with a plasma glucose of 90 mg per dl; and protein, 34 mg per dl. The India ink preparation was negative as were CSF cultures and smears for bacteria and mycobacteria. No treatment was given, and a repeat lumbar puncture was done with consultation 6 hours later. The CSF then showed red blood cells (RBCs), 347 per ul; WBCs, 169 per ul (mostly lymphocytes); glucose, 30 mg per dl; and protein, 62 mg per dl. Her peripheral WBC count remained normal at 7,800 per ul; the platelet count had risen from 156,000 to 303,000 per ul.

Despite a temperature spike to 38.9°C, severe headache, rigors, myalgias, and arthralgias, the patient maintained a crystal-clear sensorium. A third lumbar puncture did not show any deterioration in CSF findings; they remained consistent with an aseptic meningitis of unknown etiology. Therefore, the patient was never treated with antimicrobials. On December 29, 1979, about 48 hours into the second phase of her illness, she became afebrile and improved so markedly that she was discharged the following day. She was entirely well one week later, when she returned to Honduras.

Table 1.

Results of Microscopic Agglutination Tests with 23^{a)} Leptospiral Antigens.

| ANTIGEN | Titer of serum collected on: | | |
|-------------------------------|------------------------------|------------------------|----------------------|
| | 12-26-78 ^{b)} | 12-29-78 ^{c)} | 1-2-79 ^{d)} |
| <i>Leptospira ballum</i> | — ^{e)} | 200 | 200 |
| <i>Leptospira canicola</i> | — | 200 | 800 |
| <i>Leptospira copenhageni</i> | — | 100 | 200 |
| <i>Leptospira mankarso</i> | — | 100 | 100 |
| <i>Leptospira andamana</i> | — | 100 | 200 |
| <i>Leptospira autumnalis</i> | — | — | 400 |
| <i>Leptospira pomona</i> | — | — | 100 |
| <i>Leptospira fort bragg</i> | — | — | 200 |

^{a)}In addition to those listed, the following antigens were used: *L. australis*, *djasiman*, *bataviae*, *celledoni*, *butembo*, *cynopteri*, *grippotyphosa*, *borincana*, *georgia*, *wolffi*, *javonica*, *alexi*, *pyrogenes*, *shermani*, *tarassovi*.

^{b)}No antibody to any of the antigens were detected in this specimen.

^{c)}No antibody detected to the 18 remaining antigens.

^{d)}No antibody detected to the 15 remaining antigens.

^{e)}— = 100.

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Sera from the patient were collected on December 26 and 29, 1978 and on January 2, 1979. All three were tested for evidence of antibody to malaria by indirect immunofluorescence with *Plasmodium falciparum*, *P. vivax*, and *P. malariae*. None was positive. In addition, hemagglutination-inhibition and complement-fixation tests were done for antibody to the following arthropod-borne viruses: eastern, western, Venezuelan, and St. Louis encephalitis, yellow fever, dengue-1, -2, -3, -4, Tensaw, and Trivittatus viruses. No antibody to any of these viruses was detected.

Microscopic agglutination tests were performed with 23 leptospiral antigens. The results, shown in the table, are diagnostic for recent leptospirosis and indicate an *L. icterohemorrhagiae* infection, as evidenced by the cross-reactivity of titer rises to *L. autumnalis*, *L. fort bragg*, and *L. pomona*; infection with *L. canicola* is less likely but possible. In leptospirosis, the infecting serotype is not necessarily the serovar showing a fourfold or greater rise in titer. Because of paradoxical reactions, the patient could have been infected with a serovar not indicated; isolation of

the etiologic agent is the only definitive means of determining the infecting organism.⁸

Discussion

There would have been little interest in reporting yet another case of leptospirosis in the United States had the patient not had an extensive travel history that opened a wide range of diagnostic possibilities for her meningoencephalitis. In retrospect, our patient's clinical illness and CSF findings were classic for leptospirosis.⁹ In 1978, 108 cases of leptospirosis were reported from 23 states. In the previous 5-year period, more than 412 cases were reported; as far as we know, none was an imported case.¹⁰ We offer this case as an instance of confusing etiology which may serve to remind clinicians that, in the differential diagnosis of a febrile syndrome, the patient's travel history may provide useful information in ruling out or further considering certain diseases of infectious etiology. In such cases, the aid of state, federal, or other competent diagnostic laboratories should be enlisted in the effort to confirm clinical suspicions. When an individual has an extensive history of travel, the most exotic diseases must be considered, even if your practice is in the least exotic location.

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Perioperative Hematologic and Oncologic Problems

Martin J. Rubinowitz, MD*

Mistakes made by physicians caring for surgical patients with hematologic and oncologic disorders can be serious and even life threatening. Practical information is presented to assist physicians in managing these patients.

Patients with hematologic and oncologic diseases undergoing surgical procedures need special attention. This discussion focuses on problems that may arise and their solutions.

Malignancies

A. Compression syndromes:

The superior vena cava syndrome¹ also known as SVC, is an emergency when a patient has marked swelling of the face and neck, is dyspneic and cyanotic.

Sputum cytology is the simplest diagnostic test. The results should be obtained before performing any of the invasive procedures, which are hazardous until this disease is brought under control with treatment, usually radiotherapy. A surgical attempt to remove a lymph node or to do mediastinoscopy could result in uncontrollable bleeding. After the edema is reduced a node which was initially nonpalpable may become palpable and could then be removed.

Initial treatment for SVC consists of the administration of oxygen, diuretics, and steroids. Radiotherapy consultation should be obtained immediately even if this means transporting the patient to where it is available. The radiotherapist will usually begin treatment even without a

tissue diagnosis. Chemotherapy is not usually needed initially unless the situation is desperate. Nitrogen mustard is the most commonly used agent.

Spinal cord compression¹ is an emergency if the patient has marked paraparesis or paraplegia. Whenever a patient has persistent or otherwise unexplained back pain, especially if it is thoracic and radicular, and particularly if the patient has a known malignancy, root or cord compression should be suspected. The motor and sensory loss occur later with the former usually preceding the latter. Loss of sphincter control usually occurs late, but hesitancy may be present early. An important physical finding is vertebral percussion tenderness which is extremely common because of the frequent coexistent bony invasion by tumor. Two-thirds of plain films may be abnormal. Seventy percent of these lesions are in the thoracic spine.

The radiotherapist, neurosurgeon, and hematologist-oncologist should be consulted immediately and a joint decision should be made regarding treatment. A myelogram should be performed with neurosurgical backup because there is an 8 percent incidence of paralysis within the first 48 hours following this procedure.

Indications for radiotherapy are minimal or slowly progressing symptoms, an incomplete block on myelogram, and the presence of epidural metastases to the cauda equina. A laminectomy may be avoided in select situations, especially if the tumor is a radiosensitive, such as a lymphoma. After radiotherapy is begun the patient should be watched extremely carefully. Neurologic examinations should be performed every 2-4 hours because the patient could develop paraplegia overnight while sleeping. If a laminectomy does become necessary, radiotherapy is always indicated postoperatively because of the virtual

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impossibility of completely removing the tumor.

The patient who has severe, rapidly progressing neurologic deficits with a complete block on myelogram should have an emergency laminectomy. Surgery will not be of value for patients whose paralysis is total and of long duration. If the patient has been paralyzed for only a few hours, surgical decompression may be worth a try.

High dose steroid therapy should be started immediately to reduce edema. There is some recent data indicating that 100 mg of Decadron rather than the usual 16 mg in the first 24 hours may be of greater value in dire situations.

Chemotherapy is not usually needed initially. Drugs may cause marrow depression which can delay the completion of radiotherapy.

Aggressive treatment is definitely worthwhile. The degree of success depends upon the pretreatment ambulatory status of the patient.² Sixty percent of patients who were ambulatory prior to treatment remained so afterwards. Thirty-five percent of paraparetic patients and only 7 percent of paraplegic patients became ambulatory post-treatment.

The ultrasound and CT scan³ are excellent non-invasive studies for distinguishing extrahepatic from intrahepatic obstruction. These procedures have an accuracy rate of over 90 percent. The CT scan can sometimes demonstrate the etiology and site of obstruction. If not, the transhepatic or retrograde cholangiogram usually will.

A percutaneously inserted Teflon prosthesis⁴ can decompress the biliary tract in patients with unresectable malignant disease who are poor surgical candidates.

B. Effusions:

Certain practical points regarding tapping and treatment of pleural effusions⁵ are important.

Intracavitary therapy should not be administered on the first tap. Fluid for cytology and culture should be obtained. If the culture is positive intracavity therapy is contraindicated because it may cause loculation of infected areas. Systemic antibiotics should be given.

Intracavitary therapy can be administered with or without chest tube drainage. The agent most widely used is nitrogen mustard which can be given by the washout technique. After most of the fluid has been removed the medication is instilled. The patient is turned in several positions, and 15 to 30 minutes later the tube unclamped and the remainder of the medication removed.

This method is highly effective and minimizes bone marrow depression.

For patients with low blood counts, non-bone marrow suppressing agents such as bleomycin,⁶ tetracyclines⁷ and radioactive P₃₂ can be used. Diuretics can be tried initially and may control malignant effusions fairly well for a variable length of time. If 120 mg of Lasix and 100 mg of Aldactone are not effective the patient should be tapped. The recommended sequence is to first tap the patient, obtain cytology and culture, and start diuretics. Patients who have positive cultures should be treated with antibiotics. Intracavitary therapy should be administered to those patients whose cytology is positive and culture is negative and have rapid reaccumulation of fluid.

The echocardiogram is an excellent test for diagnosing pericardial effusions. A chest x-ray is less reliable. The cardiac silhouette may appear normal on some occasions, although the classical picture of the water bottle shaped heart is often present. Pericardiocentesis should be done by an experienced physician because of the risk of a potentially fatal arrhythmia or coronary artery hemorrhage. One must not assume that the effusion is due to tumor. The patient who has had previous radiation therapy to the area can develop a radiation induced pericardial effusion months or even years later.

The best tolerated agents administered into the peritoneal cavity for ascites are bleomycin and P₃₂. Radioactive gold can cause adhesions resulting in intestinal obstruction at a later date. Colloidal agents such as P₃₂ are useful for small peritoneal implants, but are of no value for larger masses. A venous peritoneal shunt⁸ can be inserted in patients who have severe refractory ascites.

C. Aggressive malignancies:

Some patients with widespread aggressive malignancies who look terminal initially may be potentially curable. Emergency treatment for these patients is of extreme importance. Potentially curable malignancies include Hodgkin's disease for which there is a five year survival rate of 40 percent even with the most advanced or Stage IV disease, diffuse histiocytic lymphoma for which there is a 40-50 percent complete remission rate and most of these patients may be cured and nonseminomatous testicular carcinoma for which there is a 75 percent complete response rate in advanced or Stage III disease with only a few late relapses. Patients with these diseases

who are being referred for aggressive treatment should have all pathologic material sent with them. The diagnosis can then be confirmed and appropriate treatment instituted promptly.

D. Surgery in patients with hematologic disorders:

Patients with malignant hematologic disorders should have their disease well controlled before proceeding with surgery. Operative intervention should be avoided if possible in patients who have acute leukemia or end stage lymphoma. Those patients who have uncontrolled polycythemia vera present a special problem. They are at great risk for both hemorrhagic and thrombotic complications. In one series⁹ the morbidity was 46 percent in patients with uncontrolled disease, but was only 5 percent in those whose disease was controlled. Patients requiring emergency surgery should be phlebotomized preoperatively. P_{32} and the alkylating agents act too slowly to be of value in this setting.

Chemotherapy should be discontinued preoperatively and should not be resumed postoperatively until at least two weeks have elapsed. The patient can respond more effectively to potential parasurgical infections while off chemotherapeutic drugs.

E. Diagnostic Procedures:

1. Estrogen receptors:¹⁰

To obtain estrogen receptors, the surgeon should remove tumor tissue (at least $\frac{1}{2}$ cm cube is needed), trim the fat, and send it promptly to the pathologist, either fresh or on dry ice. The specimen should not be put in formalin which has the effect of ruining such tests.

Estrogen receptors (ER) can be determined on both primary and metastatic breast carcinoma lesions. If the ER status is unknown, estrogen receptors should be determined on metastatic lesions from skin, subcutaneous, bony, and epidural sites. Surgical subspecialists should be reminded to obtain tissue for ER. Any patient who has an axillary or cervical node with an unknown primary should have ER done. A positive test would indicate that a breast primary is likely and mastectomy may be indicated. Patients with metastatic breast carcinoma who are ER positive have a 60 percent chance of responding to hormonal manipulation, be it additive or ablative. Those who are ER negative have less than a 10 percent response rate.

2. Metastatic workup:

The routine studies that should be ordered include a complete blood count, liver functions, and

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TABLE 1

Lymphangiogram

1. Advantages

- a. A definite diagnosis may be established
- b. Directs the surgeon to involved nodes
- c. Useful for follow-up because the dye remains in the nodes for a prolonged period of time
- d. Will detect normal sized diseased nodes in the inguinal, iliac and periaortic areas

2. Disadvantages

- a. May obscure the pathologic diagnosis
- b. May add to the debilitation of a marginal patient
- c. Complications including oil embolization
- d. Ten percent false positive and fifteen percent false negatives
- e. Will miss early obturator node involvement in many GU and GYN malignancies and mesenteric node involvement in non-Hodgkin's lymphoma

a chest x-ray. The bone scan should be done if the patient has one of the primaries (i.e. lung, prostate, kidney, breast, and thyroid) that spreads to bone with some frequency. A bone survey is a much less sensitive screening test. There is usually 30-50 percent destruction of bone by tumor before plain films become abnormal. When a bone scan is positive, plain films of the involved areas should be taken. A liver scan should be ordered if either hepatomegaly or abnormal liver functions are present. The yield is very low in the absence of those abnormalities.

The carcinoembryonic antigen or CEA¹¹ has been most widely used for following patients with colon carcinoma. This test may also be elevated in some patients with other gastrointestinal tract primaries and carcinoma of the lung, breast and genitourinary tract. It should be obtained prior to surgery, and if elevated, every six weeks to three months postoperatively. A slightly elevated stable level lacks the significance of a steadily rising value, which is virtually diagnostic of progressive disease.

Patients who have a negative test preoperatively shouldn't have serial CEA tests postoperatively because the tumors are presumably non-CEA producers, as for example 30-40 percent of colon cancers are. Serial determinations during the first three months after surgery are often confusing because the CEA may rise initially, possibly due to CEA release into the circulation and then fall. The CEA is frequently positive in low

titer, that is less than 10 ng/ml in many benign hepatic and pulmonary diseases. The upper limit of normal is less than 5 ng/ml in most laboratories.

A rise in CEA may antedate symptomatic recurrence by three months or longer. A series of second look procedures for colon carcinoma¹² demonstrated that the CEA was 88 percent accurate.

3. Radiographic procedures:

The advantages and disadvantages of lymphangiography are listed in Table I and should be weighed carefully prior to performing the procedure. The gallium scan is noninvasive and is useful for detecting disease above the diaphragm, especially for lymphomas, lung carcinomas, and abscesses. The yield below the diaphragm has been a disappointing 50 percent. The sonogram is useful for following extra-bowel recurrences of abdominal and pelvic malignancies, but can only demonstrate lesions which are two cm or larger. Thin patients are more easily studied than obese patients. The CT scanner has utility in the head, chest, abdomen, pelvis, and bones. CT scanning is superior to sonography in obese patients and in those who have a lot of abdominal gas which makes sonograms uninterpretable in about 20 percent of patients.

4. Exploratory laparotomy:

The previously mentioned tests, particularly the sonogram and the CT scan, can produce false positive results.¹³ The decision to explore a patient should be based on symptoms, signs, laboratory results, and diagnostic procedures. Patients who have a positive sonogram or CT scan as the only abnormal finding should have the test repeated before the surgeon proceeds with an exploratory laparotomy.

F. Staging procedures:

Surgical staging should be performed on patients with Hodgkin's disease¹⁴ only if the patient is a reasonable surgical risk and the treatment program would be changed by finding abdominal disease. Staging operations for non-Hodgkin's lymphomas¹⁵ are primarily being done in research centers. They are especially useful for upstaging diffuse histiocytic lymphoma. This disease may be curable with aggressive chemotherapy in advanced stages, and if understaged may be undertreated with radiotherapy. The surgeon should take on-operating table films to ensure re-

July

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13-17 17th Annual Course in Internal Medicine. Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241. (25 hours of AMA Category 1 credit).

20-23 24th Annual Ruldoso Family Practice Seminar. Inn of the Mountain Gods at Mescalero, New Mexico. Contact: Bob Reid, Convention Director, 412 Bassett Tower, El Paso, Texas 79901. (915) 533-3449. (18 hours of AAFP credit).

20-24 The Comprehensive Care of the Diseased & Injured Upper Extremity: The Colorado Hand Surgery Education & Research Foundation, Rose Medical Center, and the Colorado Committee on Trauma of the American College of Surgeons will sponsor an International Symposium on Hand Surgery. Seminar to be held at Keystone Lodge, Keystone, Colorado. Contact: John A. Boswick, Jr., M.D., 4200 East E. 9th Avenue, Box C-309, Denver, Colorado 80262. Tele: (303) 394-8718. (Seminar meets criteria for 34 hours Category 1 credit, Physicians' Recognition Award of the AMA).

22-25 Current Concepts in the Surgical Pathology of the Thyroid, Parathyroid, Thymus, and Mediastinum. Santa Fe Hilton Inn, Santa Fe, New Mexico. Contact: W.J. Levy, M.D., Symposia de Santa Fe, P.O. Box 5175, Santa Fe, New Mexico 87501. (505) 982-1911. (14 hours of AMA Category 1 credit).

7/23-8/20 Controversies 2: An Ongoing Course in the Practice of Pediatrics. Contact: Health Education Department, The Children's Hospital, 1056 East 19th Ave., Denver 80218. (303) 861-6947. (AMA credit available on an hour-by-hour basis).

24-25 Use of the CO₂ Laser in Ent. Beth Israel Hospital, 1601 Lowell Blvd., Denver, Colorado. Contact: Beth Israel Conference and Institute Program, P.O. Box 11366, Denver 80211. (303) 629-5333. (12 hours of AMA Category 1 Credit).

26 Practical Gastroenterology for the Internist and the Family Physician. Aspen, Colorado. Contact: Office of Postgraduate Medical Education,

University of Colorado School of Medicine, 4200 East 9th Ave., Denver 80262. (303) 394-5241. (15 hours of AMA Category 1 credit; 15 hours of AAFP credit).

7/31-8/2 Ear, Nose, Throat for the Family Practitioner. The Lodge, Vail, Colorado. Contact: Lisa Lee, Associates of Otolaryngology, 950 East Harvard, Suite 500, Denver 80210. (303) 744-1961. (22 CME credits).

August

3-6 24th Annual Pediatrics Postgraduate Course. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241.

3-6 Gynecology. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, C-295, Denver 80262. (303) 394-5241.

9-13 Perinatal Medicine. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. 394-5241. (21 hours of AMA Category 1 credit).

10-13 Perinatal. Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Avenue, C-295, Denver 80262. 394-5241. (21 hours of AMA Category 1 credit).

10-14 Aspen Conference on Pediatric Disease, 1981 - Tumors. The Gant, Aspen, Colorado. Contact: J. Thomas Stocker, M.D., Department of Pathology, The Children's Hospital, 1056 East 19th Avenue, Denver 80218. 861-6712. (27 hours of AMA Category 1 credit).

14-15 Use of the CO₂ Laser in Gynecology. Beth Israel Hospital, 1601 Lowell Blvd., Denver. Contact: Beth Israel Conference and Institute Program, P.O. Box 11366, Denver 80211. (303) 629-5333. (12 hours AMA Category 1 Credit. Applied for 12 ACOG Cognates).

14-18 Primary Care Orthopedics. Aspen, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241.

19-22 The Kidney in Systemic Illness: Malignancy, Pregnancy and Connective Tissue Disease. The Given Institute of Pathobiology, Aspen, Colorado. Contact: Office of Postgraduate

Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241. (16 hours of AMA Category 1 credit; 16 hours of AAFP credit).

20 Anemia Work-Up. Vail, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80203.

28-29 Rheumatology - A Postgraduate Clinical Experience: Sponsored by the Joe and Betty Alpert Arthritis Treatment Center, Rose Medical Center, Denver. Contact: Dorothy M. Bailey, Office of Education, Rose Medical Center, 4567 East 9th Ave., Denver 80220. Tele: (303) 320-2102. Category 1 credit & AAFP Prescribed Credit Offered. Fee: \$125.

29-31 Tutorials in the Tetons: Clinical Cardiology - Diagnostic and Therapeutic Advances. Jackson Lake Lodge, Grand Teton National Park, Moran, Wyoming. Contact: Mary Anne McInerney, Extramural Programs Department, American College of Cardiology.

September

3-5 29th Annual James T. Waring Chest Conference. Longs Peak Inn, Estes Park, Colorado. Contact: Tony Marostica, American Lung Association, 1600 Race Street, Denver 80206. (303) 388-4327. (10 hours of AMA Category 1 credit).

4-6 Pediatric Neurology Mini-Course. Keystone Resort, Colorado. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Avenue, Denver 80218. (303) 861-6949. (AMA Category 1 Credit available).

October

5 What You Should Know About Anticoagulants. Burlington, Colorado. Contact: Martin Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80202. (2 hours of AMA Category 1 Credit; 2 prescribed hours of AAFP Credit).

10-11 The Charley J. Smyth Symposium on Arthritic and Rheumatoid Conditions of the Upper Extremity. The Fairmont Hotel. Contact: John A. Boswick, Jr., M.D., 4200 East 9th Avenue, Box C-309, Denver. (303) 394-8718. (14 hours of AMA Category 1 Credit).

20-25 General Medicine. Hilton Head Inn, Hilton Head Island, South Carolina. Registration Tuesday, October 20th - 4:00-6:00 p.m. Contact: Beth Israel Hospital, Conference Program, P.O. Box 11366, Denver 80211. Denver Metro Area: (303) 629-5333; Outside Colorado (800) 525-5810.

November, 1981

8-15 Update in Clinical Endocrinology and Infertility: Hilton Head Inn, Hilton Head Island, South Carolina. Registration Sunday, November 8. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver 80211. Tele: (303) 629-5333. Toll-free outside Colorado: (800) 525-5810.

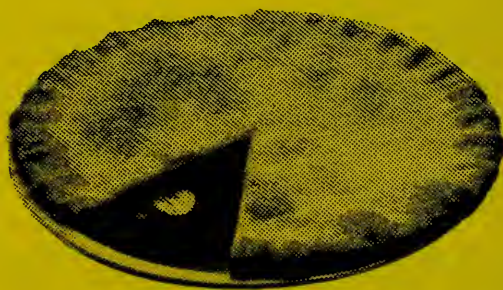
December, 1981

10-12 The Management of Patients with Burn Injuries: Brown Palace Hotel. Contact: John A. Boswick, Jr., M.D., 4200 E. 9th Ave., Box C-309, Denver 80262. Tele: (303) 394-8718. (18 hours of AMA Category 1 credit).

January, 1982

9-16 Current Clinical and Legal Issues: The Mark, Vail, Colorado. Contact: Beth Israel Conference Program, P.O. Box 11366, Denver, Colorado 80211. Tele: (303) 629-5333. Toll-free outside Colorado: (800) 525-5810.

11-15 13th Annual Cardiovascular Conference at Snowmass: Snowmass Resort. Contact: Registration Secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014. Tele: (301) 897-5400.



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TABLE 2**Coagulation Screening Tests**

1. Bleeding time
2. Prothrombin time
3. Partial thromboplastin time
4. Platelet count
5. Clot observation for formation, retraction and lysis.

removal of the involved nodes and place silver clips around diseased areas to assist in postoperative radiotherapy planning.

Ovarian carcinoma is frequently understaged because of inadequate surgical procedures. Many surgeons do not explore the upper abdomen adequately. In a National Cancer Institute series¹⁶, nine out of 16 patients who were supposed to have localized pelvic disease were upstaged primarily by finding subtle subdiaphragmatic carcinoma. Second look procedures may be performed on patients who appear to be clinically free of disease after one year of treatment with chemotherapy. Patients who have had a negative second look operation have a remarkable 90 percent five year survival off treatment.

Bleeding and Clotting Disorders:**A. Thrombocytopenia:**

Thrombocytopenia is an emergency when the platelet count is under 20,000 and the patient has significant bleeding. Under these circumstances five or six platelet packs should be administered. Fresh whole blood can be given if volume is needed, but the patient is at risk for developing congestive heart failure. Platelet packs are of little or no value for patients who have idiopathic thrombocytopenic purpura (ITP), drug-induced thrombocytopenia and disseminated intravascular coagulation without the concomitant use of heparin.

Steroids are indicated for patients with ITP and immune thrombocytopenia secondary to lupus, chronic lymphocytic leukemia and lymphoma. Splenectomy is beneficial for most patients who are steroid failures, being 75 percent successful for those who have either ITP or lupus induced thrombocytopenia.

A patient who is bleeding massively and needs prompt referral should have his blood type determined immediately. The physician to whom the patient is being referred should be notified. If the patient has a rare type such as B negative, such

communication will enable the blood bank to search for donors before his arrival.

B. Coagulation Disorders:

A bleeding history should be elicited even from gravely ill patients or their relatives. Symptoms that are suggestive of a coagulation defect include bleeding from multiple sites, excessive bleeding from a single site, post-dental extraction bleeding of greater than 24 hours duration, excessive postsurgical or perinatal bleeding, bilateral epistaxis and spontaneous ecchymoses. The latter are not tender, whereas traumatic ecchymoses are. Palpation may help make the distinction. The diagnosis may be obscured in those patients who have had multiple transfusions. In this setting a coagulation workup should be done on available family members. A coagulation screen such as the one listed in Table 2 should be ordered on patients with suspected bleeding disorders.

Disseminated intravenous coagulation (DIC) occurs most often in patients with sepsis and hypotension. The presence of the triad of thrombocytopenia, elevated fibrin split products and low fibrinogen, is consistent with but not absolutely diagnostic of DIC. The most important part of the therapy of DIC is the effective treatment of the underlying disease. Heparin in full therapeutic doses is used only when there will be a delay in controlling the disease while life threatening bleeding is occurring. Patients who have had previous thromboembolic complications or a family history of same may have familial antithrombin 3 (AT₃) deficiency.¹⁷ AT₃ levels should be checked on available family members.

Postoperative bleeding requiring a large number of transfusions may be due to technical problems or a coagulation defect, most often the former. Patients who have already received ten units or more of banked blood should subsequently be given one unit of fresh blood for every three units of banked blood.

Minidose heparin¹⁸ therapy has been shown to be of value perioperatively for patients undergoing abdominal, thoracic and urologic surgery. The results in patients having orthopedic surgery are less impressive, possibly because patients with hip fractures are actively clotting, and low dose heparin is ineffective.

Miscellaneous Problems:

Patients with acute abdominal pain and leukopenia usually do not have a surgical abdomen.

Viral illnesses and lupus can present in this fashion. A conservative approach is appropriate although occasional exploration is necessary to rule out a coexistent acute surgical problem.

Hereditary spherocytosis should be suspected in any patient who is anemic, has an elevated reticulocyte count and an elevated mean corpuscular hemoglobin concentration (MCHC) greater than 36. Spherocytes are often missed on smear and may not be reported. These patients frequently have gallstones necessitating a cholecystectomy. Splenectomy should be done first and then cholecystectomy. If the spleen hasn't been removed and an emergency develops so that premature

closure is necessary, the patient is still at risk for a fatal aplastic crisis postoperatively. After splenectomy has been performed this risk no longer exists.

Summary

Practical information is presented concerning the perioperative care of patients with hematologic and oncologic problems. It is important that patients who present with emergencies and those who need elective surgery be managed properly to minimize complications and maximize the potential benefits to be derived from their surgical procedures.

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Neoplasms of the Colon, Rectum and Anus: Maus W. Stearns. NY, Wiley, 1980. 206 p. \$24.50.

Surgery of the Anus, Rectum and Colon: John C. Goligher. 4th ed. London, Bailliere, 1980. 968 p. \$110.00.

Tumors of the Pancreas: A.R. Moossa. Baltimore, Williams & Wilkins, 1980. 560 p. \$62.00.

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Current Urologic Therapy: Joseph J. Kaufman. Philadelphia, Saunders, 1980. 517 p. \$42.50.

General Urology: Donald R. Smith. 9th ed. Los Alton, CA, Lange, 1978. 541 p. Gift.

The Kidney: B.M. Brenner and F.C. Rector, ed. 2nd ed. Philadelphia, Saunders, 1981. 2 v. \$120.00.

Renal and Electrolyte Disorders: Robert W. Schrier, ed. 2nd ed. Boston, Little, Brown, 1980. 624 p. \$22.95.

SURGERY

Critical Surgical Illness: James Hardy, ed. 2nd ed. Philadelphia, Saunders, 1980. 702 p. \$42.00.

Long-Term Results in Plastic and Reconstructive Surgery: Robert M. Goldwyn, ed. Boston, Little, Brown, 1980. 2 v. \$95.00.

Surgical Pediatrics: Stephen L. Gans, ed. NY, Grune & Stratton, 1980. 310 p. \$32.50.

Surgical Radiology: A Complement in Radiology and Imaging to the Sabiston Davis-Christopher Textbook of Surgery: George J. Teplick, ed. Philadelphia, Saunders, 1981. 1088 p.

obituaries

Dr. William Francis Drea, a retired oral surgeon, radiologist and bacteriologist, died May 15, 1981 at a local hospital.

Dr. Drea was born September 5, 1885, in East Cambridge, MA, and later graduated from the Harvard University School of Dentistry.

He was an honorary trustee of Webb Waring Lung Institute, emeritus member of the American Medical Association, and a member of the Colorado State Medical Society, the El Paso County Medical Society, the American Dental Association, and the Colorado and El Paso Dental Societies.

He was an active member of the New York Academy of Sciences, the American Microbiological Society, the American Bacteriological Society, American Chemical Society, American Biochemical Society, Society for Applied Spectroscopy, and the Harvard Alumni Association.

Survivors include his wife, Helena Chase Drea of Colorado Springs; a daughter, Charlotte Drea Rising of Delores; three sisters, Mary, Agnes and Margaret Drea, all of Watertown, MA; a brother, John Drea of Bedford, MA; and four grandchildren.

Contributions may be made to the Tutt Library at Colorado College.

Dr. John F. McFarren, M.D., died May 19, 1981. Dr. McFarren has been a member of the Clear Creek Valley Medical Society since 1963. He was in private practice in Arvada from 1960-1964, and at 4045 Wadsworth in Wheat Ridge from 1974-1980. January 16, 1981,

Dr. McFarren was approved for the Active Member on Leave classification by Colorado Medical Society.

Dr. Von H. Brobeck, M.D., died Thursday, May 21, 1981, at a local hospital. He was born December 13, 1897, in Wellington, IL. He had been an ophthalmologist in Colorado Springs since 1922.

Dr. Brobeck attended Dartmouth College, University of Vienna in Austria, University of Illinois, University of Wisconsin, University of Pennsylvania Medical School and was graduated from Northwestern University Medical School.

Dr. Brobeck was a member of the American Medical Association, American Academy of Ophthalmology, Colorado Ophthalmological Society, Colorado Springs Ophthalmological Society, Pan American Ophthalmological Society, and the Pacific Coast Ophthalmological Society.

Dr. Brobeck was a staff member at Penrose, Memorial and St. Francis Hospital.

Survivors include his wife, Florence Brobeck of Colorado Springs and a daughter, Mrs. Helen Gallup of Seattle.

ANNUAL SESSION
Keystone, Colorado
September 9-12, 1981

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CHOLESTEROL: THE OTHER SIDE

YOUR COLLEAGUES SPEAK OUT

AMERICAN COUNCIL ON SCIENCE AND HEALTH

As a result of its analysis of the scientific literature, the American Council on Science and Health concludes that it is premature to recommend basic changes in the diets of most Americans as a means of preventing Coronary Heart Disease (CHD), except to recommend weight control. Individuals at high risk of CHD should follow the advice of their physicians.

Although there is evidence of greater risk for the obese person, a strong relationship between specific nutrient levels and CHD has not definitely been established. The American Council believes that a nutritious diet that includes moderate amounts of a variety of foods from the Basic Four Food Groups and avoids consumption of excessive calories should be recommended to all Americans. In other words, moderation, variety and balance are the keys to good nutrition and health and better function of all organs, including the heart.

'TOWARD HEALTHFUL DIETS'...FOOD AND NUTRITION BOARD

Cholesterol is an essential metabolite and is actively synthesized by the human body in amounts of 800 to 1,500 mg. daily. In contrast to many species, man absorbs cholesterol poorly, permitting the entry of only 10-50 percent of that in the diet (Dietschy and Wilson, 1979). There is a curvilinear relationship between dietary cholesterol intake and serum cholesterol concentration in man, as evidenced by a slope that decreases with increasing cholesterol intake from about 12 mg/dl of serum cholesterol/100 mg dietary cholesterol/1000 calories at low levels to less than 2 mg/dl/100mg/1,000 calories at high levels (Keys et al., 1965; Ahrens et al., 1979). This effect is due to the poor absorption of cholesterol at high levels, plus feedback mechanisms in the body that adjust biosynthesis to body needs. No significant correlation between cholesterol intake and serum cholesterol concentration has been shown in free-living persons in this country (Kannel and Gordon, 1979; Nichols et al., 1976). For these reasons, the Board makes no specific recommendations about dietary cholesterol for the healthy person.

MEAT IN NUTRITION-AN INTERNATIONAL SYMPOSIUM

"Our average life expectancy in the U.S.A. has increased since 1900 from 40 years to 73 years. We have never been healthier. And they tell us meat is going to kill us. Where is the evidence for man? Where is the hard evidence? Where is the hard evidence for man that animal fats or cholesterol in human diets are serious, strong risk factors in the development of arteriosclerosis, particularly in the coronary arteries? In vegetable eating rabbits? We are not rabbits nor mice nor rats. Not even monkeys? The data from many flawed epidemiological studies have been mentally masticated and digested for years in scientific circles all over the world, and we still have no hard data for man."

Dr. Robert M. Kark

Rush Medical College and Presbyterian-St. Luke's Hospital
Chicago, Illinois

"The vegetable oil manufacturers in this country are advertising their products as 'cholesterol free' as if that were tantamount to 'germ-free', 'poison-free' and 'coronary artery disease-free'. Cholesterol has become the nutritional bogeyman of the times, and according to these advertisers, is to be avoided as if it were a carcinogen. Actually cholesterol is an essential metabolite, and if it were not synthesized in the human body at the rate of 1.0 gram per day, it would be a nutrition essential..."

Dr. Robert E. Olson

St. Louis University School of Medicine
St. Louis, Missouri

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July 1981

Volume 78, Number 7

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ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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This month's cover inaugurates a new CMS campaign for physicians towards becoming a "proactive" force in organized medicine, rather than maintaining the "reactive" stance

which has become the plight of so many physicians. The article, by William Pierson, CMS Director of Communications, appears on page 257.

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As Relief for Degenerative and Rheumatoid Arthritis

Donald C. Ferlic, MD, and Mack L. Clayton, MD, Denver, Colorado

Applying principles of hip and knee replacement to the upper extremities.

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Associated with a Secundum Type Atrial Septal Defect

Donald B. Jenny, MD, Howard T. Horsley, MD, Donald H. Kearns, MD, and W. Gerald Rainer, MD, Denver, Colorado

The eighth case of infective tricuspid endocarditis associated with an isolated arterial septal defect of the secundum is reported.

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258 GMENAC forecasts 38% Increase

in Number of Otolaryngologists by 1990 and Says That's About Right—But Is It?

William H. Call, MD, GMENAC Delphi Panel Member

Report on how the study was conducted, past research in particular on the Delphi Technique, and a conclusion that the recommendations of GMENAC "should not be used by government of other agencies to alter the total number of mix of residencies available."

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To the Editor:

The UPI story of the two-pound baby who was flown to Augusta for medical care deserves comment.

Like Colorado, Florida has developed a model system of maternal and newborn transport, perinatal outreach education and perinatal centers to improve the outcome of pregnancy. Variations on that theme are now in place throughout the country with some 400 perinatal centers and systems.

When one or more of the regional centers are overloaded with patients or short of staff and/or equipment, it is a good and common practice to divert a referred baby to another and sometimes distant center. Not to do so may compromise care of the sick infant.

The lack of funding for the flight to Augusta apparently triggered the call to the White House and led to the dispatch of a C-130 transport plane to move the baby and her support systems to Augusta. At best, a makeshift transport arrangement. There was a failure of the IV, heat and respiratory support systems. These incidents are rarely encountered in well organized transport services, such as Children's Hospital's Newborn Emergency Service.

Instead of demeaning the Florida centers who were unable to take the baby, it would be more constructive to focus on the need for adequate state funding of regional perinatal centers, including the key component of the transport service.

It is totally bizarre to expect the Pentagon to launch 77-ton transport planes whenever a financial emergency exists. A systems ap-

proach using local components with state funding is more sensible. Hopefully, the 1982 general assembly will agree.

L. Joseph Butterfield, M.D.
Denver, Colorado

Dear Editor:

I read with interest your comments about the "top five health issues" in a recent addition of the *Colorado Medicine* ("... At Press Time," *Colorado Medicine*, May, 1981, p. 143). It is of

interest that the traditional issue—that is, finding cures to leading causes of illness and death—is ranked third in your consumer survey. I would agree that the cost of health care is the number one issue but would rank finding cures for various illnesses (that is, continuing medical research) as the number two issue. I would rank the health environment as third. I would change number two issue from changing of lifestyles to the category "consumer education on health issues," and rank this fourth. The fifth health issue I would list as "the influence of government and other third party payers on health care delivery."

I have certainly enjoyed the (*Colorado Medicine*) journal recently, and I congratulate you on the changes in format which you have made. I am sure that there are now many physicians, statewide, who are actually reading it completely.

Sincerely yours,

James G. Urban, M.D.
Aurora, Colorado

Dear Mr. Urban:

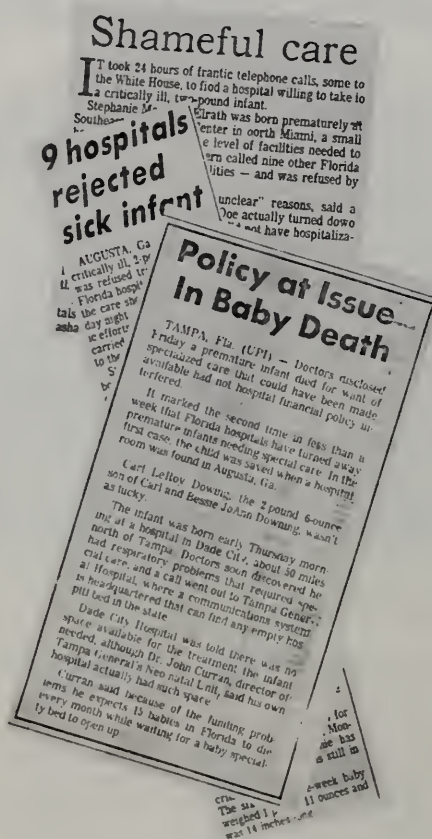
According to your re-evaluation, the "Top Five Health Issues" would look like this:

1. Cost of health care and medical treatment
2. Continuing medical research
3. Health environment
4. Consumer education on health issues
5. Influence of government and other third-party payers on health care delivery.

Is it not practical to think of your #5 being a direct influence on #1? Most physicians, I believe, would agree that the preponderance of federal and state regulations concerning health care delivery certainly do escalate the cost of such services; therefore, federal and state regulations and third-party payers should be considered a major factor in the cost of health care and medical treatment.

If you accept this proposition, you still have one slot to fill. What's your choice?

Editor



A Journal for New Mexico

For 41 years the *Rocky Mountain Medical Journal* had been the official scientific voice of the Colorado, Montana, New Mexico, Nevada, Utah and Wyoming medical societies, and the linkage was close and productive, but as Goethe said, "We must always change, renew, rejuvenate ourselves, otherwise we harden."

We do modify our thoughts, but often forces outside of our scientific and political orbit compel changes. Clyde Stanfield, the last chief scientific editor of the *Rocky Mountain Medical Journal*, pointed out that the decline of state medical journals could be attributed to an insidious creeping inflation, and the federal decision to tax scientific journals for "unrelated income." As a consequence, over a period of several years the state medical associations of Montana, Nevada, New Mexico, Utah and Wyoming withdrew because of their needs to trim their budgets. The final blow came when the Colorado Medical Society decided to discontinue the journal.

Within the past several years, the governing boards of the Nevada,

Utah and New Mexico medical societies have affiliated with *The Western Journal of Medicine*, and the need for a voice in a scientific journal was satisfied. In addition to these states, *The Western Journal of Medicine* also represents California, Idaho and Washington.

From an historical perspective, the linkage of New Mexico and California goes back to 1846, when the Mexican War erupted. Remember Manifest Destiny? General Stephen Watts Kearny, commander of the Army of the West, was ordered to occupy New Mexico and California. In 1846,

Santa Fe was captured, and subsequently the Stars and Stripes were raised over the City of Angels.

With our common origin, we look forward to a long and cousinly relationship with our western partner California, and the four other states that make up *The Western Journal of Medicine*.

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The CMS Professional Liability Insurance Trust

Renewals are now out for those of us in CMS whose professional liability insurance will expire in July, August, and September.



Each of you has received or will soon receive a renewal notice and application with the opportunity to renew your liability insurance with either a fully insured Hartford program or with a deductible, administered through the Medical Society Trust. I encourage each of you to examine the figures and note the following characteristics:

The price is the same for the next policy year whether you renew with pure Hartford insurance or with the Trust.

There is no risk to the physician who renews with the Trust, since this still remains an occurrence-type insurance coverage with the same characteristics and the same limits available as previously.

The only way that we can achieve savings through a Medical Society insurance company is to begin now to develop both management abilities and dollar savings, which can flow to a company that has reduced administrative expenses, no profit motive, and premium rates based purely upon Colorado experience.

The risk management efforts, the claims management, and the legal defenses remain the same in the ex-

isting program as has been previously the case.

This is the smoothest possible transition to a doctor-owned company which can then, over time, achieve the stability and economy characteristic of the doctor captives across the country and which are most desirable for Colorado physicians.

In the June issue of COLORADO MEDICINE we listed the majority of the questions which had been asked by both physicians and administrators of CMS, accompanied

by the answers from the insurance underwriters, our brokers and our insurance consultants. Hopefully, these questions, and the answers supplied, will have fulfilled your immediate needs. I am certain there will be others. I urge you to contact me or CMS staff members and give us the opportunity to find the answers to your specific questions.

Your response thus far to the Trust has been highly encouraging, but the need for every possible CMS member participation is vital to your successes.

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24-HOUR ANSWERING SERVICE

This year, we have made significant format changes in the Annual Session of the House of Delegates, to be held at KEYSTONE, SEPTEMBER 8-11, 1981. These changes have been made in an effort to avoid some conflicts that have arisen in previous years, and to afford everyone of their opportunity to participate in the events of their liking.

The session kicks off with golf and tennis tournaments all day Tuesday, September 8, and a welcome reception that same evening hosted by Keystone Lodge.

On Wednesday, September 9, the Scientific Program will be presented. It should be most interesting this year with the theme being "The Environment." During the morning there will be speakers on the topic of "The Air As Environment." At 11:00 a.m. Brian O'Leary, noted national author on Science Policy and Space Exploration, will present the Keynote address on "Exploring New Worlds and Space Colonization." Mr. O'Leary is a well-known speaker and author and has written extensively on science topics, having covered the Columbia launch for the "Today" show. He is a speaker you will not want to miss.

During the afternoon the topics of various speakers will be "Radiation in the Environment," both nationally and in Colorado. Further information on speakers will be forthcoming shortly.

On Thursday, September 10, at 8:30 a.m., the House of Delegates will convene for its first session, and later that morning the Colorado Foundation for Medical Care will hold its Annual Meeting. Reference Committees will meet at 1:00 p.m., and that evening there will be a President's Reception and Western Barbeque.

Friday, September 11, we are encouraging the component societies and Districts to hold caucuses at approximately 10:00 a.m. Reference Committee reports will be available at this time. Over the past two years we have had enthusiastic response from caucuses and look forward to a repeat of that this year. At 1:00 p.m., the House of Delegates will meet for the last time to consider Reference Committee reports.

We look forward to your comments, following the meetings, concerning the new format and hope that this Annual Session will be an interesting and educational experience for everyone.

Richard Bedell, MD, Speaker of the House, Colorado Medical Society

CMS Annual Session

Keystone Lodge; September 8-12, 1981

Preliminary Schedule of Events

TUESDAY, SEPT. 8

Tennis & Golf

Evening

Welcome Reception Sponsored by Keystone Lodge

WEDNESDAY, SEPT. 9

Morning

Scientific Program
Medical Executives Group
CMS Finance Committee

Afternoon

Scientific Program
CMS Board of Directors
CMS/CFMC Joint Board of Directors

Evening

Auxiliary President/President-elect Reception
Specialty Presidents' Dinner Meeting
CMS/CFMC Board of Directors Dinner

THURSDAY, SEPT. 10

Morning

Prayer Breakfast
CMS House of Delegates

Auxiliary Board Meeting

Auxiliary Brunch

Reference Committee Chairmen Luncheon

Afternoon

Reference Committee Hearings
Auxiliary General Meeting & Session for County Presidents/Presidents-elect

Evening

President's Reception/Dinner

FRIDAY, SEPT. 11

Morning

COMPAC Breakfast
Auxiliary Workshops
District Caucuses

Afternoon

CMS House of Delegates
Auxiliary Tennis

SATURDAY, SEPT. 12

Morning

CMS Board of Directors Reorganizational Meeting
Medical Assistants Meeting

The 40 day deadline for receipt of resolutions to be considered by the House of Delegates in September is Friday, July 31. A fiscal note will be attached to all resolutions. For assistance in developing the fiscal information, please contact Chris Stein or Susan Clark at the CMS executive office.

POETRY CONTEST

A \$1,000 grand prize will be awarded in the upcoming poetry competition sponsored by World of Poetry, a quarterly newsletter for poets.

Poems of all styles and on any subject are eligible to compete for the grand prize or for 99 other cash or merchandise awards, totaling over \$10,000.

Says Contest Chairman, Joseph Mellon, "We are encouraging poetic talent of every kind, and expect our contest to produce exciting discoveries."

Rules and official entry forms are available from the World of Poetry, 2431 Stockton, Dept. J, Sacramento, California 95817.

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CMS Building Project Report

The Colorado Medical Society has purchased the option to buy 5 to 10 acres of land at South Broadway and County Line Road in south Littleton in a new commercial office development called "South Park."

The decision to make this step for CMS has been the result of long and careful deliberation as well as the consideration of many alternatives.

A. CMS will have to find new quarters sometime in the not-too-distant future because the needs of the organization are too great for the amount of space immediately available. Currently, CMS is working under a growing burden of insufficient space for its present programs, councils and committees, not to mention staff and equipment.

B. There is the very strong possibility that the Denver Library Foundation may not be able to provide the lease space which CMS now occupies. CMS would then be faced with a very sudden decision as to how to move and where to move.

C. The continued payment of lease fees is a dead-end expense. An equity base can be built in your own structure for all physician members.

There are MANY positive aspects to the decision which has been made:

A. The building will benefit you the physician in many ways;

1. Build up of equity,
2. Stabilized dues and operating expenses,
3. Investment for participating physicians,
4. A structure with meeting rooms, possible food facility, free parking for members, and,
5. An improved physician's image.

B. The township in which the new property is located is extremely anxious to have the Colorado Medical Society headquartered with-in its limits; therefore, the leadership of the City of Littleton has been most helpful in putting together a financing package which can fit the needs of the Society at this time.

C. Building a structure to house CMS and ancillary organizations will allow CMS to be in the landlord rather than in the tenant position. This will promote better planning and use of the space.

D. Moving the CMS headquarters to an area which is fast becoming the major focal point of metropolitan Denver growth is a plus in itself.

E. Building is just one more move toward Colorado physicians becoming the masters of their own destiny, whereby a doctor-owned property will pay proceeds to each investor and to all members of CMS.

F. The practice of medicine is rapidly changing during this new decade, and CMS must be able to move with the change. For this, CMS must have a firm base of operations. Nothing can give the entire society a better base than the fact that it is moving with the commercial and economic tides, and is firmly fixed in its location for years to come.

Many considerations went into the decision of locating in south Littleton.

Of primary importance is the proximity to major highways, thoroughfares and overall transportation access to the location. When the C-470 highway is completed, it will provide six-lane transportation between I-25 and I-70. In addition, County Line Road will be expanded to four lanes. Santa Fe Drive will be expanded to a six-lane, minimal access thoroughfare which will support north/south traffic in addition to Broadway. There will not be the major traffic jams which are occurring downtown and along the I-25 corridor with the Denver Tech Center, Inverness and Greenwood Plaza.

Secondly, the site provides a spectacular and panoramic view of the front range from Pikes Peak on the south to Long's Peak on the north, with the added emphasis of the entire downtown Denver skyline in the foreground to the north.

Third, and no less important, the Colorado Medical Society would like to see a facility designed specifically for membership organizations and activities. The building and environs will be entirely attuned to the activities and needs of your organizations and their members.

Of concern to us all is the spiraling cost of space. Costs cannot be projected at this time, however, the creative financing of the building will allow for extremely affordable rates, especially in consideration of the quality and unique, functional design of the building.

If you have any interest at all in being a major force in the movement of the CMS to a very permanent and prominent location for many years to come, please contact Joseph Poynter, M.D., Chairman, Building Committee, CMS, Jerry Bowman, Executive Vice President, CMS or Chris Stein, Executive Director of Finance and Operations, CMS.

(Continued on Next Page)

Amigos Training Report

With pleasure, some regret, and deep appreciation to a great number of people, training for the 1980-81 Denver Amigos ended on June 3, 1981. The esteemed medical director, Dr. John Hult, gave his usual outstanding performance and marked this year's Amigos with his "The Finest Group Ever" stamp. Jennifer Clegern, Gina Liggett, Steve Zonner, Joan Liddell, Pauline Koyama, and Bob Kastner were the reliable week in - week out people who, along with Dr. Hult, made the training process work. Dr. Lewis Picher, a psychologist, Dr. Kevin Evans, a dentist, and Dr. Osgoode Philpott, Jr., a dermatologist, all made unique contributions. Former Amigos, parents, and friends of parents all added an enormous amount to the total activities that make up six rather rigorous months of training.

One of the Amigos in training, Jaime Alva, also made a fine total contribution. He taught the First Aid and CPR training classes. In addition, he added to the cultural discussion and human relations activities, and taught Spanish faithfully at each training session.

As is always the case, everyone wished that they could have had more time. They covered the recommended outlines that come as suggested training activities. Human relations, Spanish instruction, cultural awareness, and medical training, plus special instruction in the several different programs in the participating countries might best describe in very broad terms what they tried to accomplish. The real pleasure that comes with working with young people is watching their personal growth and contribution over a period of time. As training ended, there was more and more realization that what there is in the 1980-81 Denver Amigos goes far beyond that which is contributed during training. They are unique young people, with personality characteristics of their own, but with a level of cooperation that comes with group activity over a period of time. They are now a part of the larger Denver Amigo Family and everyone should expect much and be proud.

Western Occupational Health Conference

The theme for the 1981 Western Occupational Health Conference's 25th Silver Anniversary Session is "Regulation, Friend of Foe." The Oct. 7-10 event is set for the Doubletree Inn, Monterey, CA. Attendance of 800 is expected.

Five major health professional groups: Physicians, nurses, industrial hygienists, health physicists and safety engineers representing WOMA, WAOHN, AIHA, ASSE and HPS have jointly prepared the program.

Registration forms are available from Joe Donovan, 433 Palmer Ave., Aptos, CA, 95003, (408) 688-9667.

C.E. Credit is approved for physicians and nurses; other credit approvals are pending. Pre-registration fees vary from \$50 to \$65; student fees are \$25. Specials workshop fees range from \$20 to \$35.

BME Renews Commitment to CME Requirement for Relicensure

On July 9th the Board of Medical Examiners held a hearing to consider a proposal to amend the regulations governing the continuing education requirement for relicensure. This amendment essentially would recind the requirement.

The Colorado Medical Society's Council on Professional Education and Board of Directors unanimously opposed the amendment. Representatives of the CMS, including Patrick G. Moran, M.D., Chairman, Council on Professional Education, testified at the July 9th hearing to oppose the amendment.

Following the hearing, the Board of Medical Examiners voted to continue the current regulations whereby each physicians must accrue 20 accredited (Category 1) hours of continuing medical education in each calendar year for the purpose of relicensure.

Questions pertaining to the hearing may be directed to Kevin Bunnell, Ed.D., Director, Division of Continuing Education and Public Health (303) 861-1221 X262.

1981 Oktoberfest Mini-marathon

The Midwest's only 10 kilometer run for health professionals will be held in Omaha, Nebraska, October 4, 1981 at 3 p.m., at the University of Nebraska Medical Center.

The fourth annual Oktoberfest Mimi-marathon is open to health science personnel and hospital employees in Nebraska and the surrounding states of Colorado, Iowa, Kansas, Missouri, South Dakota and Wyoming.

The race will be held in conjunction with the university's annual Oktoberfest, one of the nation's largest public health fairs. This year's Oktoberfest will feature Richard Simmons, host of the Emmy Award winning show on NBC-TV.

With the start and finish on campus, the 6.2 mile Mini-marathon course traverses the somewhat hilly terrain of south-central Omaha, covering some of the city's most scenic and historic areas.

Trophies will be awarded to the top male and female runners overall and the fastest male and female physicians, phamacists, nurses, dentists and allied health professionals.

T-shirts will be given to all entrants.

For more information, or to register (\$4 entry fee), contact Dave Ogden, Office of Public Affairs, University of Nebraska Medical Center, 42 and Dewey, Omaha, NE, 68105.

THE
WESTERN PHYSICIANS
PURCHASING ASSOCIATION
ANNOUNCES
GOOD NEWS
FOR
COLORADO PHYSICIANS

More suppliers, better service, and worthwhile dollar savings are now particularly accessible to Colorado doctors through the Western Physicians Purchasing Association. There are now four medical-surgical, two X-Ray, an office supply, and two office furniture suppliers immediately at hand in the Denver-Colorado Springs area to provide WPPA members service by telephone or direct sales contact; and at reduced pricing!

Many other services have been added in the new WPPA catalog, such as automated laboratory services out of Denver. Now all services and materials are available by direct order from your office to the appropriate vendor, including the automobile lease or purchase programs.

As one of our WPPA members commented recently; "The service is good, the price is right." Nothing in life is free, Doctor, and some motivation and effort is needed on your part to perfect reasonable savings in your purchasing as a means of cost control in your practice. If you would like to inspect our new WPPA catalog to determine if it would be of benefit in your situation, please contact us. If you like what you see, send us your \$50 per physician per calendar dues. If not, return the catalog.

For information or catalogs, please direct your inquiry to: Mr. Bill Upton, Executive Director, 425 East 5350 South, Suite 212, Ogden, Utah 84403 (801-479-1767), or to John F. Kahle, M.D., President, 715 N. Beaver St., Flagstaff, AZ 86001 (602-774-8692).

AAMA Dedicated to Medical Assistants

The American Association of Medical Assistants, Inc. (AAMA) is a professional organization for medical assistants, secretaries, nurses, technicians, bookkeepers and receptionists who work in a physician's office or another medical facility. It is a national, non-profit organization dedicated to the professional advancement of medical assistants. Its educational services enable members to increase their effectiveness to the physicians and patients they serve. The following is a summary of information about, and services offered by, the AAMA.

Membership—Medical assistants are individuals who work in doctor's offices, hospitals and other facilities, performing both administrative and clinical duties. In Colorado there are five statewide chapters:

Capitol Chapter; affiliate: Denver Medical Society.

Clear Creek Valley Chapter; affil: CCVMS.

El Paso County Chapter; affil: El Paso Co. Med. Soc.

Fremont County Chapter; affil: Fremont Co. Med. Soc.

La Plata County Chapter; affil: La Plata Co. Med. Soc.

You will also find at-large members throughout the state. For membership information or applications, contact Candia Beetha at 1028 E. Boulder, Colorado Springs, 80909, or inquire at the CMS component medical society in your area.

The prime purpose of AAMA is the education of medical assistants. In addition, the association cooperates in sponsoring workshops for medical assisting educators. Many materials, such as an Educational Program Planning Packer, an audio-visual aids list and certification review aids, are available from the Executive Office to help state societies and local chapters plan effective programs at seminars and meetings. Other con-

tinuing education sources are:

1. Guided study programs consisting of cassettes and workbooks. These programs enable assistants to learn at their own pace on their own time.

2. Self assessment programs are offered which consist of 100 questions designed to test individual knowledge. The questions are scored by the participant and a rationale of the answers is provided for immediate feedback on performance.

3. The official bi-monthly journal, *The Professional Medical Assistant*, is devoted to original articles written for medical assistant by their peers or other professionals in related fields. It is an automatic benefit of membership.

4. The annual convention each fall offers a variety of experts in medical and related fields. These speakers address participants during educational programs and workshops. CEU credit is available for selected workshops and a special program for medical assistant educators is presented each year at this meeting.

5. Seminars and workshops are sponsored throughout the year by local and state medical assisting groups or by regional collaboration. Here again, selected workshops are approved for CEU credit.

The AAMA encourages advancement of medical assistants by offering a Certification Examination designed to evaluate professional competency. Those who successfully complete the examination are entitled to use the CMA designation (Certified Medical Assistant) after their names.

Candidates may also earn specialty certifications in administrative (CMA-A), clinical (CMA-C), and pediatric (CMA-Ped) categories.

The AAMA Curriculum Review Board is recognized by the U.S. Commissioner of Education as an official accrediting agency for medical assisting programs. There are 117 accredited programs across the United States, both in public and private sectors of education.

The Dorothy and Henry Bodner Loan Fund for Certification and Education provides financial assistance in those fields, with no interest rate.

Drug Fraud Alert

DRUG—Ambenyl Exp.

On June 23, 1981, a Spanish-American female using the name Paula Burns attempted to pass a forged Ambenyl prescription on Boulder Community Hospital pads, Dr. Thomas. Paula Burns gave a Denver address of 1704 Fillmore and is described as age-unknown, 5' 5" tall, medium build, black hair and a tattoo on her left inner forearm. Apparently, there is no Dr. Thomas at Boulder Community Hospital.

DRUG—Ambenyl Exp.

Dr. Paul Rhodes, 232-1113, has been plagued by persons calling pharmacies, impersonating him or his receptionist, and prescribing Ambenyl. Please call and verify any Ambenyl prescriptions with Dr. Rhodes, phone 232-1113. Dr. Rhodes is a pediatrician.

DRUG—Percodan

Stolen prescription pads from Donald D. Hanna, M.D., 3535 S. Lafayette, Englewood, phone 761-3653. Dr. Hanna's office reports prescriptions and refills for Percodan and Pen-Vee K are being passed. Call Dr. Hanna to verify all prescriptions for Schedule II drugs at 761-3653.

DRUG—Percodan/Percocet

Dr. Roy Lininger, DDS, 3470 S. Sherman, Englewood, phone 781-6911 reported that a man using the name Kevin Bruning, age 25, 5' 10" tall, 160 pounds, blond hair, blue eyes, is "doctor shopping" with an old, unfinished root canal. If you get a prescription from this subject, call the prescribing dentist and ask him if he was aware Bruning is seeing other dentists for a root canal. The dentist may want to cancel the prescription or lower the quantity of tablets prescribed.

Regulatory Reform

The Administration has created an office to oversee the necessity of Federal Regulations. Rules or Regulations to be reviewed may be those that sanction, establish procedure or interpret policy.

Major rules are to be reviewed for their potential costs and benefits to society. Mr. Reagan's executive order (12291) indicates that alternatives are to be developed for such rules and that the "alternative" involving the least net cost to society shall be chosen.

A major rule is characterized as one which produces an effect of 100 million dollars or more on the economy; one which produces significant price increases in the public or private sectors; or one which has significant adverse effects on competition.

If you wish to petition for a review of such a regulation write to Dr. Miller, Executive Director of the Task Force on Regulatory Relief, Office of Management and Budget, Executive Office Building, Washington, D.C. 20503.

AMA Physician's Advisory Panel Moves, Expands Services To Entertainment Industry

CHICAGO—The American Medical Association's Physician Advisory Panel, which has been providing medical technical assistance to the radio, television and motion picture industries since 1955, has moved its offices from Hollywood to AMA headquarters in Chicago.

The move will expand the panel's services to script writers, producers and directors by providing direct access to the AMA's extensive medical library and its 140 computerized data bases of scientific information. To provide continuity, the panel members—more than 24 practicing physicians representing about a dozen specialties—will remain the same.

Panel members are experts in the fields of internal medicine, cardiology, cosmetic surgery, psychiatry, dermatology, pediatrics, pathology, urology, obstetrics and gynecology, radiology, ophthalmology and hyp-

nosis. They provide medical technical assistance and script review services to a variety of radio and television shows and the major motion picture studios. In addition, some panel members have been able to provide original script ideas from case experiences in their own practices.

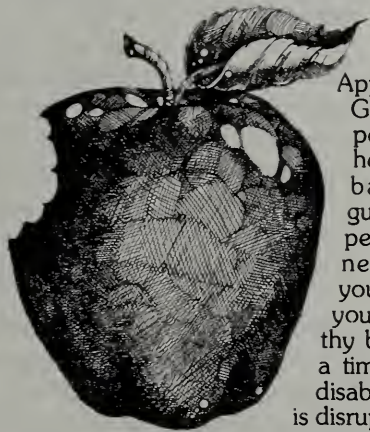
Services of the AMA Physician's Advisory Panel are free. Coordinator is Dorothy Brown, assistant director of the AMA's Department of Consultative Services/Radio, TV and Motion Pictures.

The panel staff may be reached at (312) 751-6511, from 9 a.m. to 4:30 p.m. Central Time, Monday through Friday. Most telephone inquiries can be handled within one hour. A staff member will contact a physician in the appropriate specialty, then get back to the writer with the physician's response. Messages left after office hours will be handled the following morning.

The following offer a glimpse of the variety of questions the panel members are asked to answer.

- Is human blood used for transfusion in chimpanzees?
- How long after a cesarean section

Will an apple a day keep the doctor away?



Apples alone won't do it. Good nutrition is an important part of staying healthy, but even a well-balanced diet can't guarantee that an unexpected accident or sickness won't happen to you. You can help keep your financial picture healthy by planning ahead for a time when you may be disabled and your income is disrupted.

That's why the Colorado Medical Society endorses Disability Income Protection for its members. This plan can provide you with a regular monthly benefit when a covered sickness or injury keeps you from your practice. You can use your benefits any way you choose — to buy groceries, make house or car payments or provide for

your children's education. And Disability Income Protection, underwritten by Mutual of Omaha, is available to members of the Colorado Medical Society at Association Group rates.

For complete information on how you can keep your financial picture healthy, mail in the coupon or contact the Mutual of Omaha representative nearest you for personal, courteous service.

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2950 N. Academy Blvd., Building D
Colorado Springs, CO 80907
Phone (303) 574-3450

Con Litz
Suite 300, 4800 Wadsworth Plaza
Wheat Ridge, CO 80033
Phone (303) 423-2710

Frank Zarlengo
Suite 111, Building 3, 6000 E. Evans Ave.
Denver, CO 80222
Phone (303) 758-3600

Carl Roderick
Greeley National Plaza, Suite 660
827 8th St., Greeley, CO 80631
Phone (303) 352-5296

Colorado Medical Society Insurance Program

I am interested in Mutual of Omaha's personal service in providing me with information about Disability Income Protection available to me as a member of the Colorado Medical Society.

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Address _____

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People you can count on...

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Home Office: Omaha, Nebraska

can a woman resume lovemaking?

- If a person was electrocuted by a murderer at a party, what would a paramedic see that would make him realize it was electrocution rather than a heart attack?

- If a physician were giving a patient a routine chest examination, what symptoms could he detect that would make him think the patient has a fatal disease?

Dr. Clarke Elected National Medical Society Official

J. Philip Clarke, M.D., F.A.C.P., of Denver, has been elected a Governor of the 51,000-member national medical specialty society by the American College of Physicians (ACP).

As Governor, Dr. Clarke keeps the ACP members in his region up to date on College policies and activities, advises the ACP ruling body of matters concerning his region and recruits and endorses new College members and Fellows. Planning and conducting an annual regional meeting consisting of a scientific program and ACP activities as well as representing the College to the public are also part of Dr. Clarke's gubernatorial responsibilities.

Dr. Clarke, a 1946 graduate of the University of Colorado, is an endocrinologist.

The American College of Physicians works to upgrade the quality of medical education, practice and research through rigorous membership requirements, programs of continuing medical education and contact with health care officials in government and private sectors.

Dr. Amilu Martin, Member of CMS Board, Appointed to AMA Committee

Amilu S. Martin, MD, F.A.C.S., Colorado Springs, Colorado, has been appointed to the American Medical Association's Ad Hoc Committee on Women in Organized Medicine from the Rocky Mountain Region.

Dr. Martin, upon accepting the appointment, pointed out that "the average percentage of women in medical school is now at the 30% range, and I believe it is in our best interests to begin to learn to know how

to reach this new group of physicians, in order to have them become a part of organized medicine."

Dr. Martin went on to say, "Certainly, it will be necessary for our membership goals for the Colorado Medical Society in the future."

Among the top priorities of the 1979-1980 organization year, K. Mason Howard, MD, President of the Colorado Medical Society stated women's physician groups involvement in the organized medicine efforts was a necessary factor to the continued success of such professional efforts. Dr. Howard has, in fact, placed special emphasis on building such relations between CMS and women physician groups. It was with this in mind that the Colorado Medical Society did nominate Dr. Martin to the AMA Ad Hoc Committee on Women in Medicine. Dr. Howard expressed his pleasure to the membership and Dr. Martin in her appointment to this prestigious national committee.

Brian Stutheit and Robert FitzGerald Leave CMS for the Private Practice of Law

Colorado Medicine recently learned that Brian K. Stutheit, J.D. and Robert M. FitzGerald, J.D., are soon to be engaged in the private practice of law. Mr. Stutheit will be practicing with the Denver firm of Miller and Swearingen. Mr. FitzGerald will be practicing at the United Bank of Denver.

Both gentlemen will be missed by our physician community. Mr. Stutheit actively represented CMS interests with the Board of Medical Examiners, Chiopractors, lawyers and other professionals. He helped to author Colorado's new Controlled Substance law. His advice in the areas of medical staff affairs and office operations will be missed greatly.

Mr. FitzGerald is a veteran in the field of administrative and antitrust law. Bob hopes to continue to serve physicians in the areas of medical remuneration and practice management.

These energetic men are a reminder to the public of organized medicine's dedication to quality patient care.

Dennis Hoogland Named to Serve USP

Dennis Hoogland, Ph.D., Senior Vice President of Benedict Nuclear Pharmaceuticals, Inc., Golden, was named to serve on an Expert Advisory panel of the United States Pharmacopeial Convention (USP). Dr. Hoogland is considered to be an expert in the field of radiopharmaceuticals and will work with the USP in its drug-use information programs.

As a member of the panel Dr. Hoogland will help develop, review and revise drug monographs for the annual editions of *USP Dispensing Information* and *About Your Medicines*, a new lay language drug-use handbook. He will also be involved in the continuing drug education and information programs of USP.

In addition, the advisory panel provides advice to the USP Committee of Revision for development of the official standards of strength, quality, purity, packaging and labeling.

Roy Atkinson, M.D. Accepted to ACR

Roy J. Atkinson, M.D., 3805 S. Niagra Way, Denver, CO has been selected for Fellowship in the American College of Radiology (ACR) in honor of his special contributions to the medical profession.

Dr. Atkinson will receive his award during the annual meeting of the ACR in Las Vegas September 21-25. The ACR is the professional medical society representing 18,000 physicians who specialize in the use of radiation and ultrasound to diagnose and treat human disease.

Dr. Atkinson, a native of Denver, is a 1952 graduate of the University of Colorado School of Medicine. He is affiliated with Porter Memorial and St. Joseph Hospitals in Denver.

Alfred Adler and Vaslav Nijinsky— New Light on an Old Case

CHICAGO—A previously unpublished work by Alfred Adler, the famous German psychoanalyst, will be published in the July issue of the American Medical Association's *Archives of General Psychiatry*. The work was written in 1936 as a preface

to *The Diary of Vaslav Nijinsky*, the renowned Russian ballet dancer.

Nijinsky's career was cut short by a severe mental disorder, probably schizophrenia. Although some of the most famous psychoanalysts of the period examined and treated Nijinsky, Adler seemed to be the most hopeful about his recovery. Although Adler did not treat Nijinsky, Nijinsky's wife, Romola, was so heartened by Adler's opinion that she asked Adler to write a preface to the *Diary*.

The preface consists of Adler's theory of severe mental illness and some of the factors in Nijinsky's life that led to his illness. Adler stressed the then-controversial notion of inferiority complex but omitted Romola's role in Nijinsky's disorder.

The accompanying discussion by Dr. Heinz L. Ansbacher of the University of Vermont revealed that Romola was displeased by Adler's focus on Nijinsky's problems, and particularly by the notion that Nijinsky had an inferiority complex. Romola rejected Adler's preface and wrote a glowing one herself.

Dr. Ansbacher states that the preface had not been released earlier by the Adler estate out of courtesy to Romola. After Romola Nijinsky died in 1978, Adler's son, Kurt, released the preface to Dr. Ansbacher.

This work sheds light on the tragic decline of a world-famous artist and the theory of one of the most important and influential psychoanalysts of the twentieth century. It is the only published first-hand professional opinion of the case of Vaslav Nijinsky.

Child Health Council Awards

Dr. Elmer Franz, an orthopedic surgeon from Englewood, was recognized as "Outstanding Physician" during the Child Health Council luncheon May 21, at Windsor Gardens in Denver. Dr. Franz was recognized for his 23 years of outstanding service to the Health Department's Handicapped Children's Program.

Dr. Franz started private practice in 1948 as an orthopedic surgeon and plans to retire in August of this year. He has held orthopedic clinics twice a year for the past 23 years for handicapped children in Yuma, Washington, Morgan, Logan, Phillips and Sedwick counties.

Dan Gossert, who presented the award to Dr. Franz, said, "We never heard a cross word from him and he's never complained. He has given exceptional service."

Also recognized at the luncheon were Chris Fonseca, 17, of Fort Morgan and Mrs. Jennie Diesslin of Nathrop.

Chris, a junior at Fort Morgan High School, was named "Handicapped Achiever of the Year". The award was given to a handicapped youth whose rehabilitation has required extensive medical care and coordination of

services and whose progress has been outstanding.

Chris entered the Handicapped Children's Program when he was three years old. Today he has published one book of poems and is in the process of writing another. He is a reporter for his school newspaper and has been student manager of the baseball, football and track teams the last three years.

Mrs. Jennie Diesslin was given the "1981 Outstanding Volunteer Award" for her efforts in helping children with special needs in her community.

Grievance of the Month

Editor's note: the "Grievance of the Month" column appears each month as an aid to your private practice. Names, of course, are fictitious, but the circumstances are those reported in grievances handled by your CMS Grievance Committee.

Complaint: A few days after moving into the city, Mrs. Right had taken her 10-year old son to the Emergency Room on a Wednesday morning with a laceration of the foot. Dr. Rushed was the "on call" physician and had arrived promptly, sutured the laceration and instructed Mrs. Right to bring the child to the office the following Friday for a dressing change and wound check. On Thursday morning, Mrs. Right had received a call from Dr. Rushed's office stating that the doctor would not be in and that the appointment had been changed to the following Monday. On Saturday, the patient complained of increasing pain in the foot and, by Sunday, the patient was worse, swelling and redness were apparent in the foot and ankle.

Mrs. Right's letter explained she had taken her son to see Dr. Ohno, her neighbor's physician. Dr. Ohno had removed the sutures and placed the patient in the hospital, casually remarking that the cellulitis could have been avoided had he seen the patient 48 hours earlier.

Mrs. Right's letter explains that the patient had been in the hospital five days and the hospital bill

had been in excess of \$900 and that did not include Dr. Ohno's bill. Her complaint was that Dr. Rushed had sent a bill in the amount of \$64 for suturing the wound. Mrs. Right felt that this was an unreasonable charge for 20 minutes' time in the emergency room, especially since the suture had to be removed before healing of the wound could occur.

Investigation: Dr. Rushed's records indicated that he had irrigated and sutured a 3.5 cm laceration of the foot. He had not expected to be out of the city on the following Friday at the time he made the appointment with the patient. Dr. Rushed informed the Grievance Committee that he felt his charge was reasonable and thought the infection was an unfortunate, but not rare, complication of such an injury. He further stated that had Mrs. Right taken her son to the emergency room when he became worse on Saturday, he would have been seen by the physician covering Dr. Rushed's E.R. calls. Dr. Rushed stated that he felt Mrs. Right's complaint was unjust and that he expected full payment.

Resolution: A second communication from the Grievance Committee to Dr. Rushed advising that there was value in seeking compromise was not answered within one month. And six weeks after the original complaint, Dr. Rushed informed his carrier that he had received notice of **litigation** regarding the case.

Could you be Dr. Rushed ... or Dr. Ohno?



Members of the Colorado Medical Society and Auxiliary take well deserved pleasure as they are presented with a check for more than \$14,000.00 by the AMAERF Committee. They are (l to r) Kathy Thompson, outgoing President of the CMS Auxiliary, K. Mason Howard, MD, President of CMS, Mrs. Thelma Schwartz (wife of M. Roy Schwartz, MD, Dean of University of Colorado School of Medicine), Ruth Yost, Chairman, Colorado AMAERF Committee (Ruth, with the billboard she's wearing, is not too obvious in her support of the ERF), and R. G. Bowman, Exec. Vice President, CMS. Ruth's Committee of Auxiliary members raised the money through their various efforts during the year, and then the Auxiliary presented the check to the CMS, which in turn, presented the money to the University School of Medicine. Thelma Schwartz is the School of Medicine Liaison with the CMS Auxiliary.

Pediatricians Guidelines For Children's Sports

School and community officials planning sports programs for children younger than 13 years should remember that "young children are not miniature adults". The American Academy of Pediatrics asks officials to avoid features common to highly competitive athletics, such as excessive publicity, pep squads, high pressure public contests, paid admissions or other forms of "exploitation of children in any way".

Another factor to consider when athletic activities for children are organized, is that "there is no physical reason to separate preadolescent children by sex in sports, physical education and recreational activities". However, girls should not com-

pete against boys once the boys have reached puberty since girls then will have less muscle mass per unit of body weight.

Other guidelines for sports programs geared to elementary school age children appear in the June issue of *Pediatrics*, The AAP's official journal.

Children's competitive sports programs should be designed so that all children can participate, not just the physically gifted, the well developed or the precocious. Therefore, officials should encourage sports such as bowling, golf, skating, swimming, tennis and running, which fit the special needs and capabilities of this age group.

To minimize risk of injury both play conditions and supervisors' qualifications should be monitored care-

fully. The Academy adds that this is especially true when children compete in sports in which players risk collision, such as in football, wrestling, soccer, ice hockey, basketball, baseball and softball.

Other highlights of the Academy's guidelines include recommendations that adequate medical care be available during games and practice; that players be grouped according to weight, size, physical condition, skill and physical maturity; and that facilities for the sport be well maintained.

The American Academy of Pediatrics is an organization of more than 22,000 board-certified pediatricians dedicated to the health, safety and well-being of infants, children and adolescents in North and South America.

Study Discredits Food Coloring As Cause of Hyperactivity

CHICAGO—The Feingold diet has been tested and found wanting as a cure for hyperactivity in children, says a report in the current issue of an American Medical Association specialty journal.

The diet eliminates artificial food colorings, on the presumption that these additives are responsible for hyperactivity in small children. It was advanced some years ago by Ben F. Feingold, M.D., and has been widely used in treatment of hyperactivity.

Reporting in *Archives of General Psychiatry* for June, Jeffrey A. Mattes, M.D., of Bronx, N.Y., reports on studies conducted among children age 4

to 13 who had been on the Feingold diet and whose parents reported that the children responded dramatically to the diet.

The study was designed as what researchers term the "double-blind crossover with order randomized." This reportedly eliminates any element of chance in the findings.

Children were referred through local chapters of the Feingold Association. The Nutrition Foundation provided cookies composed of natural ingredients of the type recommended in the Feingold diet and free of artificial food colorings (placebo cookies) and another supply of cookies (active cookies) that were identical with the placebo batch in taste and appearance. Each contained a mixture of all Food and Drug Administration-approved artificial food col-

orings reflecting normal patterns of consumption.

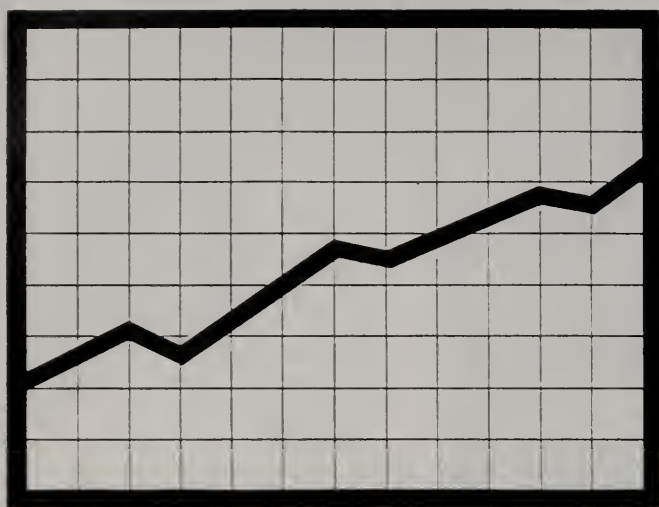
Children received both the active and placebo cookies for one week each, separated by a week with no cookies. Cookies were given at breakfast, lunch and after school. No one involved in the care and evaluation of the children knew which type of cookie the child was receiving.

Parents and teachers each completed a rating scale assessing hyperactive symptoms and a psychiatric test was administered before the study was begun. The testing then was repeated at the end of each of the two weeks in the trial.

Evaluation by parents, teachers, and psychiatrists and psychological testing yielded no evidence of a food coloring effect on hyperactivity, Dr. Mattes declares.

The past and the present: Gathered at the CMS Auxiliary Annual Meeting in Denver for the "changing of the guard" were (l to r) Sharon Ritzman, President-Elect, CMS Auxiliary, Jerry Fowler, President, CMS Auxiliary, Kathy Thompson, Immediate Past President, CMS Auxiliary, Betsy Becker, Former President, CMS Auxiliary (1979-1980), and Barbara Brown, Immediate Past President, Denver Medical Society Auxiliary.





MALPRACTICE AWARDS KEEP CLIMBING!

Colorado Physicians Form Insurance Trust
To Combat Ever Increasing
Insurance Costs!

June 1981 marks the beginning of the Colorado Medical Society Professional Liability Insurance Trust (CMS - PLIT)!

After months of negotiations with The Hartford Insurance Company, the CMS Executive Committee came to the unanimous decision that the only way to combat the rising costs of ever-increasing malpractice awards, and the continuing threat of frivolous suits against physicians was to work toward self insurance. That is what is happening!

The CMS Professional Liability Insurance Trust is the first major step toward a Physician-Owned Captive Insurance Company.

**YOU NEED THE TRUST!
THE TRUST NEEDS YOU!**

Call today! Get full details on what the CMS-PLIT means to you! If you have not received the Professional Liability Insurance Trust Program details (an information packet was sent each member in early May), call the CMS office at 861-1221 or (WATS line) 1-800-332-4150!

Every Colorado physician needs the Trust!

The Trust needs the participation of every Colorado physician!

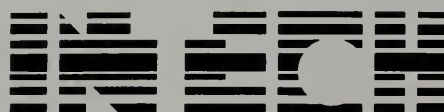
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American Cancer Society Professional Education Update

IS THC AN EFFECTIVE ANTIEMETIC FOR CANCER PATIENTS?

In 1975 Dr. Stephen S. Sallan and his colleagues at the Sidney Farber Cancer Institute reported the results of their clinical trial investigating the antiemetic efficacy of tetrahydrocannabinols (THC) in cancer patients receiving chemotherapy. This approach to emesis control originated from anecdotal accounts from patients receiving chemotherapy who reported a decrease in the incidence and severity of nausea and vomiting after smoking marijuana.

Since then, several THC clinical trials have been completed, and methodology, results, and interpretations differ. In this double-opinion Professional Education Publication, Dr. Sallan and Mayo's Clinic's Dr. Stephen Frytak present their contrasting views. They discuss THC's benefits and side effects, patient age as a factor in drug efficacy, dosages used in the trials, THC's effectiveness compared to prochlorperazine and to placebo, prior THC use, the possible connection between subjective "highs" and drug effectiveness, and the question of how THC might interact with other drugs.

Dr. Frytak concludes that although "better antiemetic agents are desperately needed," at present "the only situations where a strong case can be made for the use of THC... are in teenagers or young adults receiving chemotherapy, who have proven resistant to phenothiazines." Dr. Sallan concludes that THC is "an effective

antiemetic agent for many patients receiving cancer chemotherapy, and for some patients it may be the only effective drug."

This PEP is an excellent information source for physicians, nurses, and other members of the multidisciplinary cancer care team.

GERM CELL TUMOR OF THE TESTIS.

Recent advances have contributed to the early detection and increased curability of testicular cancer. Dr. Nasser Javadpour, Senior Investigator and Urologist-in-Chief of the National Cancer Institute, reports

on these advances - the development of accurate testicular tumor markers and of highly effective chemotherapy regimens—and he proposes a new surgicopathologic staging classification.

Dr. Javadpour also reviews various procedures for the staging of tumors and discusses the benefits and drawbacks of different therapies. Ongoing research at the NCI is cited and the course that future research should take is outlined.

The Colorado Consortium for Continuing Medical Education and a special Telecommunications Task Force sponsor **TELE-NET**.

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June 26, 1981

1. Approved Bond Underwriting agreement, subject to bond counsel approval, with Boettcher & Co.
2. Approved renewal of lease with Denver Medical Society through August 31, 1982, which incorporates a 10 percent increase.
3. Dr. Poynter discussed property purchase and building plans, including a proposed limited partnership agreement for physician ownership of the new CMS building.
4. Received written reports from the students and resident member attending their respective Section Meetings held in conjunction with the AMA.
5. Approved CMS, through the Council on Socio Economics, monitor State Health Planning bodies, with component societies monitoring HSA activities in the three HSA areas.
6. MSC to voice an objection with the Colorado Department of Social Services concerning the Disclosure Regulation, a. which allows the Colorado Bureau of Investigation to use a disclosure agreement to access a physician's practice and Medicaid records without a warrant; b. request information and definition of the normal "legal" pattern for obtaining Medicaid records; c. request clarification of the term "provider"; d. abuse and interruption of the patient/physician private relationship by this type of interference.
7. MSC to modify and adopt policy statements re Colorado Voluntary Effort: a. to strongly support

peer review by physicians of health care services for private health care programs as well as government programs; b. in order that patients may have an opportunity to compare charges and make their selection on that basis, individual hospitals and physicians should make available their charges for the most commonly billed services; c. In recognition of the fact that ambulatory surgical settings cost less than traditional hospital settings, all payors should cover medically safe procedures rendered in accredited ambulatory surgical centers; d. in an effort to educate the public as to its responsibility in cost effective medical care, all payors should offer health insurance policies which incorporate the use of co-payments and deductibles for both physician and hospital services; 3. awareness of the cost of health care services by physicians, as students, house officers and practitioners is a continuing requirement for the delivery of cost effective, quality medical care.

8. Dr. Witham reported CFMC receive grant notification for the next twelve months with the anticipated budgetary reductions.
9. In response to a recommendation from the Council on Legislation that a task force be formed to study the health care delivery system and the financing thereof in the State of Colorado, the Board responded that in the last two years data has been gathered which reflects the means of health care financing in the state of Colorado and which also reflects the component societies

and state medical society involvement in the Medically Indigent proposal, and for that reason the Board felt it unnecessary to form a Task Force at this time.

10. Request for continued support of HB 1301 was tabled until the July meeting of the Board since Dr. Edwards and Carol Tempest were not in attendance at the time of discussion.
11. Progress Report on Alternative Health Care Committee on Chiropractic Study was received for information.
12. Risk Management Committee Quarterly Report was received for information.
13. Dr. Sankey made a report on the activities of the Negotiating Committee and a report on Medicaid negotiations as requested by a District IV Director.
14. Approved Minutes of Executive Committee meetings, May 29 and June 17.
15. Approved 11-man Board structure for CMS Trust: Physician members to be current Executive Committee: K. Mason Howard, Frederick A. Lewis, Jr., Amilu S. Martin, David E. Bates, Merlin G. Otteman and R. G. Bowman. Five additional lay members to be selected.
16. Approved signing of Trust Document and Trust Agreement between CMS and the Hartford and Coverage Agreement.
17. Distributed letters from Warren & Sommer, Inc. to be mailed to the July renewals. A letter from Dr. Howard was also included.
18. Recognized Bill Pierson, Charles Marcus and Chris Stein for their efforts on behalf of Colorado Medical Society.

Colorado Foundation for Medical Care Impacts Hospital Utilization, Routine Serology Testing

The Colorado Foundation for Medical Care has been performing peer review in Colorado hospitals since 1973. In 1974, the Foundation was designated as the Professional Standards Review Organization (PSRO) for Colorado which authorized the Foundation to review the hospital care provided to all Medicare and Medicaid recipients.

During the past several months, the Foundation has been engaged in evaluating its performance to answer the question, "Does physician-based peer review really work?" The results of the Foundation's evaluation, some of which are described here, seem to indicate, in fairly definitive terms, that the answer to the question is "yes, physician participation in hospital review makes a significant difference."

From 1973 to 1979, the Foundation performed reviews of Medicare and Medicaid admissions to the hospital primarily on a case-by-case basis.

Beginning with hospital patient data collected in 1978, the Colorado Foundation for Medical Care has utilized its capabilities to compare a hospital to its peer group of hospitals through analysis of patterns of care. On occasion, individual hospital utilization has been found to be significantly different than its peer group of hospitals. In these instances, the Foundation and the hospitals have worked to resolve areas of inappropriate or questionable utilization.

Analysis of the 1978 data with respect to hospital utilization revealed that 44 Colorado hospitals demonstrated high scores in one or more of six utilization areas:

- 1) Average length of stay for all federal patients.
- 2) Average length of stay for weekend admissions.
- 3) Percent of weekend admissions.
- 4) Percent of emergency room admissions.
- 5) Percent of 1-2 day stays.
- 6) Percent of outliers, i.e., stays greater than twenty days.

Of the forty-four hospitals, fifteen were large hospitals located in large urban centers while the remaining twenty-nine were located in rural

areas or less densely populated areas of the state.

In early 1979, the forty-four hospitals were provided with their individual hospital displays with accompanying detail to enable the hospitals' medical staffs to investigate the potential problem areas, i.e., those utilization areas for which the hospital's score was significantly above the norm for its peer group.

In a number of areas, additional dialogue between Foundation Regional Council physicians and

members of the hospitals' medical staff ensued.

The Foundation recently analyzed hospital utilization patterns for calendar year 1979 for all Colorado hospitals. A comparison of the utilization patterns for the forty-four hospitals with high scores in 1978 revealed considerable change had occurred as a result of Foundation intervention. The following table clearly displays the Foundation's impact on hospital utilization rates for 1979:

IMPACT ON HOSPITAL UTILIZATION RATES 1979

STATISTICS

HOSPITALS INVOLVED

| | |
|-----------------------------------|----------|
| TARGETED HOSPITALS | 44 |
| HOSPITALS SHOWING POSITIVE CHANGE | 34 = 77% |

PATIENT DAYS SAVED

| | |
|----------|--------|
| MEDICARE | 11,783 |
| MEDICAID | 2,184 |

| | |
|--------------------------|--------|
| TOTAL FEDERAL DAYS SAVED | 13,967 |
|--------------------------|--------|

COST IMPACT

| | At \$200 per day | At \$250 per day |
|------------------------|------------------|------------------|
| MEDICARE (11,783 Days) | \$2,356,600 | \$2,945,750 |
| MEDICAID (2,184 Days) | 436,800 | 546,000 |
| GROSS SAVINGS | \$2,793,400 | \$3,491,750 |
| 1979 PSRO REVIEW COSTS | \$1,422,600 | \$1,422,600 |
| NET SAVINGS REALIZED | \$1,370,800 | \$2,069,150 |
| COST BENEFIT RATIO | 1:1.96 | 1:2.46 |

In early 1979, the Foundation elected to conduct a study of the medical necessity and cost effectiveness of routine admission Serology Testing for Syphilis (STS). This decision was based on findings in five hospitals' medical care evaluation studies which clearly indicated that the results of serology tests performed did not warrant the cost of performing this test on all admissions.

During the first quarter of 1979, data were collected retrospectively for all Medicare and Medicaid patients discharged between January 1 and March 31, 1979, in all 96 Colorado hospitals. Of the 22,450 Medicare and Medicaid patients discharged during the study period, 7,123 (31.7%) had an STS performed; of the 7,123 federal patients tested, only 104 or 1.5% had a positive STS.

After careful analysis of the study data, the Foundation's Health Care Standards Committee was asked to establish currently acceptable guidelines for the appropriate use of STS. A subcommittee of physicians from the Health Care Standards Committee consisting of representatives from Pediatrics, Obstetrics and Gynecology, Internal Medicine, Family Practice, Pathology, and Infectious Disease/Epidemiology, together with representatives from the Colorado Department of Health, the Colorado Department of Social Services, and the Colorado Hospital Association developed a policy paper on STS

which was reviewed and approved by the Colorado Foundation Board of Directors.

"The Colorado Foundation for Medical Care encourages hospitals to carry out the following:

1. Review by the medical staff of each hospital of their routine STS screening policies. Review should consist of:
 - a) tabulation and analysis of results of previous testing in the hospital,
 - b) review with the Colorado Department of Health or local health department of the incidence and prevalence of syphilis in their respective area.
2. Adoption of a policy of routine STS testing only if supported by incidence data determined by this review, and with consultation with the Colorado Department of Health.
3. Educational programs to maintain an index of suspicion for syphilis in all its stages.

To assist facilities in their review of routine serology screening the Colorado Foundation for Medical Care will supply the results of its study on Medicaid and Medicare patients.

Only a small percentage of positive hospital serologies, detected by hospital screening on all patient admissions, result in a diagnosis of infectious syphilis (primary, secondary, early latent) of epidemiological importance.

The following table, prepared by the Colorado Department of Health, shows the amount of infectious syphilis diagnosed as a result of hospital testing for the years 1975-1979. Additionally, this shows that these cases are a small percentage of infectious syphilis diagnosed from all screening sources for these years:

**INFECTIOUS SYPHILIS (PRIMARY, SECONDARY, EARLY LATENT 1 YEAR)
DETECTED BY HOSPITAL TESTING, COLORADO, 1975-79**

| | In-Patient | (%)* | Outpatient | (%)* | State Total for Year** |
|------|------------|-------|------------|-------|---------------------------|
| 1975 | 8 | (4.2) | 7 | (3.7) | 191 |
| 1976 | 7 | (2.8) | 3 | (1.2) | 254 |
| 1977 | 9 | (4.1) | 4 | (1.8) | 218 |
| 1978 | NA | | NA | | |
| 1979 | 6 | (2.6) | 2 | (0.9) | 230 |

*Percent of Total Infectious Cases.

**Total cases in the state of infectious syphilis diagnosed as a result of positive serologies reported from all screening sources."

Congratulations, Colorado Physicians!

Colorado's Professional Standards Review Organization (PSRO), operated by the Colorado Foundation for Medical Care, has been ranked 26th out of 182 PSROs in the country by a recent Department of Health and Human Services evaluation.

We congratulate you, the physicians of Colorado, for your outstanding performance in providing quality medical care that is appropriate and medically necessary.

The policy paper was forwarded to all ninety-six Colorado hospitals together with the aggregate data for all hospitals and their individual hospital study results. The hospitals were asked to review their own data and their current hospital policy on STS in light of the guidelines set forth in the policy paper.

Responses were received from ninety-five (95) of the 96 Colorado hospitals as follows: Forty-nine (49) hospitals had an STS policy of "on physician order only" prior to initiation of the study; thirty-eight (38) hospitals changed their routine admission STS protocol; one (1) hospital is considering changing its routine admission STS policy; one (1) hospital has modified its routine admission STS protocol to be applicable only to a select population; one (1) hospital had no Federal admissions during the study time period; only five (5) hospitals in Colorado have decided to maintain a routine STS admission protocol.

Of the thirty-eight (38) hospitals which changed their routine admission STS protocol, twelve (12) hospitals changed to a policy of "on physician order only" after data collection but prior to analysis of the data and twenty-six (26) hospitals changed to a policy of "on physician order only" after analysis of the study data and the CFMC policy paper.

Cost savings effected by the thirty-eight (38) hospitals with revisions of their routine STS admission protocol are substantial. The following estimates have been prepared for both federal and non-federal inpatients in

Colorado and are based on: (1) actual charges per test in 1981, (2) annualized STS rates for federal patients, (3) actual number of admissions for federal patients and non-federal patients

for 1979, and (4) an assumption that the rate of incidence of STS performed in hospitals is similar for the federal and non-federal population.

POTENTIAL ANNUAL SAVINGS AS A RESULT OF SEROLOGY TESTING FOR SYPHILIS (STS) STUDY

(BASED ON POLICIES AND PROCEDURES IN 38 COLORADO HOSPITALS)

| PAY SOURCE | POTENTIAL STS TESTS SAVED | POTENTIAL DOLLARS SAVED |
|--------------|------------------------------|----------------------------|
| MEDICARE | 25,409 | \$199,969 |
| MEDICAID | 5,999 | \$ 47,212 |
| ALL FEDERAL | 31,408 | \$247,181 |
| NON-FEDERAL | 79,377 | \$624,697 |
| ALL PATIENTS | 119,785 | \$871,878 |

Colorado Foundation for Medical Care Establishes Policy on Chelation Therapy

The Colorado Foundation for Medical Care was asked by Martin E. Segal Company, Consultants and Actuaries, to take a stand on the appropriateness of Chelation Therapy as a treatment for arteriosclerosis, whether it should be considered an eligible expense for third-party reimbursement, and if so, how charges should be considered.

A subcommittee chaired by Philip Wolf, M.D., and including Louis Hall, M.D. (family practice); Scott Pace, M.D. (internal medicine); and Dwayne Thomason, D.O. (osteopathy) arrived at the following recommendation which was approved by the Health Care Standards Committee at its meeting on April 7, 1981.

In response to claims that Chelation Therapy using EDTA (ethylene tetraacetic acid) is effective for a variety of disorders, there is no adequate evidence to indicate that this type of therapy is effective for other than acute toxicity due to heavy metal (e.g., lead) poisoning. Claims that Chelation Therapy is effective for arteriosclerosis, removal of valve calcifications, and treatment

of rheumatic disorders are without foundation. There are no controlled scientific studies that demonstrate the efficacy of Chelation Therapy in treating these disorders. Further, there is evidence of significant nephrotoxicity and case reports of other adverse effects associated with the use of EDTA. It is, therefore, recommended that third-party reimbursement should not be made for these inappropriate uses of Chelation Therapy.

The Board of Directors of the Colorado Foundation for Medical Care approved the policy statement on Chelation Therapy at the May 20, 1981 Board Meeting.

References:

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Chelating agents in medicine, in Today's Drugs. British Medical Journal 2:270, May 1, 1971.

Creven PC, Morelli HF: Chelation Therapy (Medical Information). Western Journal of Medicine 122: 277-278, March, 1975.

Soffer A: Chelation therapy for arteriosclerosis, In, when Friends or Patients Ask About...JAMA, 233: 1206-1207, September 15, 1975.

Absinthe-Induced Hallucinations Proposed as Influence on Vincent Van Gogh's Style

CHICAGO—Was it drugs or drink that helped fill Vincent Van Gogh's paintings with bright yellows and swirling golden suns and stars?

Michael Albert-Puleo, a student at Case Western Reserve University School of Medicine, Cleveland, Ohio, writes in the Journal of the American Medical Association (July 3) that Van Gogh's style may have been influenced by his fondness for the psychoactive beverage, absinthe. Previously, Thomas Courtney Lee, M.D., proposed that Van Gogh's predilection for the color yellow and for golden halos around bright objects in his paintings may have resulted from side effects of digitalis possibly used to treat epilepsy.

Dr. Lee, associate professor of surgery at Georgetown University School of Medicine, Washington, D.C., suggested that the 19th century French painter suffered from epilepsy and may have been treated with digitalis, a drug derived from the purple foxglove plant. Symptoms of digitalis overdose include yellow vision and the appearance of halos around spots of color. Although the nature of Van Gogh's infirmity and the treatment he received has not been confirmed, circumstantial evidence suggests strongly that epilepsy and digitalis intoxication played a large part in shaping Van Gogh's artistic style, Dr. Lee said.

Albert-Puleo argues that Van Gogh's use of digitalis is conjectural, but his use of absinthe, an alcoholic beverage derived from the wormwood plant, is well known and documented by first-hand reports. The habitual absinthe drinker would experience hallucinations; these, when combined with Van Gogh's apparent mental illness, "certainly played a part in the strange and wonderful visions the artist captured on canvas," Albert-Puleo believes.

Drug Law: Recordkeeping, Labeling and Pharmacist Dispensing

Recordkeeping

Under the federal Controlled Substances Act, physicians who dispense narcotic controlled substances in schedules II-IV are required to maintain a complete and accurate record of each substance received and dispensed. (21 U.S.C. 827 (c)). A physician is not required to keep records with respect to narcotic controlled substances which he prescribes or administers. "Administer" means to apply a drug to the patient via direct application by the physician or his agents (e.g., giving a shot in the office). Records kept in accordance with the law should be readily retrievable, must be kept two years from the date made, and must contain the following information:

- (a) The name of the substance;
- (b) Each finished form (e.g., 10-milligram tablet or 10 milligram concentration per fluid ounce or milliliter) and the number of units or volume of finished form in each commercial container (e.g., 100-tablet bottle or 3-milliliter vial);
- (c) The number of commercial containers of each such finished form received from other persons, including the date of and number of containers received and the name, address, and registration number of the person from whom the containers were received;
- (d) The number of units or volume of such finished form dispensed, including the name and address of the person to whom it was dispensed, the date of dispensing, the number of units or volume dispensed, and the

written or typewritten name or initials of the individual who dispensed the substance on behalf of the dispenser; and

(e) The number of units or volume of such finished forms and/or commercial containers disposed of in any other manner by the registrant, including the date and manner of disposal and the quantity of the substance in finished form disposed. (21 C.F.R. 1304.24).

Physicians are not required to keep records with respect to nonnarcotic controlled substances which they dispense unless they regularly charge for such (i.e., when they substitute their services for a pharmacist's). (21 C.F.R. 1304.24).

The recently enacted Colorado Controlled Substance Act says that "the keeping of a record required by federal law . . . shall constitute compliance with the record-keeping requirements of this part". 12-22-318.

Labeling

The aforementioned Colorado Controlled Substance Act says that physicians who dispense controlled substances other than by direct administration must affix to the immediate container a label bearing directions for use, the physician's name and registry number, the name of the patient and the date. Violation of the statute constitutes a misdemeanor punishable by a fine of up to five hundred dollars or by imprisonment for not more than one year, or both.

Pharmacist Dispensing

Colorado's pharmacist licensure statute has been amended to allow a pharmacist to refill a prescription order for any prescription drug with-

(Continued on next page.)

The legislature is recessed awaiting a congressional redistricting bill that the governor will not veto and poised to reconvene when the extent of the federal budget cuts is known. A non-partisan committee of senators and representatives has been appointed to write the redistricting bill, so perhaps some sort of compromise will be reached.

In the meantime, interim study committees have been formed and begin meeting in mid-July. Each committee meets on a monthly basis through November and this year is assigned only one subject. The eight subjects to be studied are as follows:

1. A study of the Departments of Agriculture and Natural Resources and a study of the feasibility of utilizing the Torrens system of transferring title of real property in the transfer of water rights.
2. A comprehensive study of the Highway Users Tax Fund and the future needs of the highway system.
3. A study of state lotteries consistent with the amendment approved by Colorado voters in 1980.
4. A study of the problems of the medically indigent in Colorado including the programs and services available therefor and the funding thereof; and a review of the Department of Institutions.
5. A study of property taxation and mobile home taxation.
6. A study of the necessity for constructing a new state prison.
7. A study of ways of assisting the Judicial Department in expediting the disposition of the current caseload and to examine various ways to improve the judicial system; and a study of juvenile sentencing provisions.
8. A study of the "Exceptional

(Continued on next page.)

Standards of Practice, continued.
out the prescriber's authorization when reasonable efforts to contact the prescriber fail and the pharmacist thinks the refill is necessary for the patient's health, safety and welfare. Refills made in this fashion cannot continue medication beyond seventy-two hours. Physicians may prevent such dispensing by stating on the prescription that there shall be no emergency refilling.

The Lobby, continued.
Children's Educational Act"; and the issues related to the state's system of occupational education and community, technical, and junior colleges.

The committee considering the medically indigent problem is made up of six Denverites, two from the suburbs, and three from out-of-state. Philosophically it ranges from extreme conservatism to extreme liberalism. If a bill can be written by this committee and agreed to by its members, we should be a long way toward passage of such a bill in the 1982 legislature. Strangely Representative Betty Neale (R), Denver, who has carried the medically indigent bill for two years was not appointed to this committee. Committee members are:

Representative Tom Tancredo (R), Arvada-Chairman
Senator William Hughes (R), Colorado Springs-Vice Chairman
Senator Cliff Dodge (R), Denver
Senator Dennis Gallagher (D), Denver
Senator Harvey Phelps (D), Denver
Senator Sam Zakhem (R), Denver
Representative Laura DeHerrera (D), Denver
Representative Eunice Fine (R), Greeley
Representative Jim Lee (R), Lakewood
Representative Ruth Prendergast (R), Denver
Representative Arie Taylor (D), Denver

With more time in the office now available, voting records for each legislator are being tallied, COMPAC is being restructured, and the always important thank yous are being expressed. The thank yous go too to the many CMS physicians who helped in so many ways this year. You are invaluable to the legislative effort.

A new book that comprehensively analyzes major health impairment costs in the United States has documented huge, wasteful economic penalties to the nation due to motor vehicle crash deaths and injuries; cost penalties second only to those resulting from cancer, the most costly of the four killers covered by the study.

The sponsors of the analysis have warned that public investment in research and development to substantially reduce highway crash fatalities and injuries is very low compared to the size of the problems.

The study was written by Nelson S. Hartunian and Charles N. Smart, general partners in the Boston consulting firm that bears their name, and Mark S. Thompson, an assistant professor and research associate at the Center for the Analysis of Health Practices of the Harvard University School of Public Health.

The work is entitled, "The Incidence and Economic Costs of Major Health Impairments: A Comparative Analysis of Cancer, Motor Vehicle Injuries, Coronary Heart Diseases and Stroke."

—Motor vehicle injuries significantly outpace stroke in terms of total costs and are somewhat greater than coronary heart disease. In terms of direct costs, including medical and rehabilitation expenses, they are about twice as high as either coronary heart disease or stroke.

—The annual incidence of motor vehicle crash injuries falls by far the heaviest on younger Americans

—those under 35 years old, including infants, children and adolescents - in contrast to those of the other leading impairments, which fall more heavily on older age groups. This is true both for men, a total of 2.4 million of which were reported injured in motor vehicle crashes in 1975, and women, for whom the total was 1.8 million.

—The costs of motor vehicle injuries equal the costs of coronary heart disease and exceed those of stroke by more than two to one. Yet . . . there is no great scientific effort to reduce damage sustained to people on the highway.

While the newly released book examines costs for 1975 - the latest year for which data were available to the authors - the cost it identifies have obviously grown since 1975 due to inflation in the economy at large, and the greater expenses associated with more sophisticated medical and rehabilitation equipment and techniques, and increases in highway deaths and injuries.

James L. Goodard, the former U.S. Commissioner of Food and Drugs, said: "A national tragedy is played out every day as American men, women and children are needlessly killed and crippled in motor vehicle crashes. Now, with the appearance of this study, public policymakers must face the immensity of this tragedy in terms of its burden on the national economy; and, it is hoped, do something about it."

The just-concluded 1981 AMA House of Delegates' Convention produced a number of interesting developments which will directly affect state organizations, including the Colorado Medical Society.

Among these was the reorganization of the AMA. Chiefly, a new functional profile for AMA, which redefines the basic functions of the association in a changing world. The profile was adopted by the House. Closely related to this profile was the planned dissolution of some of the present AMA Councils, such as the proposal to discontinue the Council on Long Range Planning and Development and the Council on Constitution and Bylaws. Neither was discontinued, but the House instructed the Council to hold only two meetings a year, if possible.

Concerning the Long Range Planning and Development Council, the delegates indicated that planning was clearly a function of the House.

Your Colorado Delegation introduced two resolutions. The first, Resolution 45, was concerned with charging interest on over-due accounts and the other, Resolution

46, was concerned with the Joint Commission on Accreditation of Hospitals.

A recommendation on Resolution 45 was adopted to refer it to the Judicial Council. Resolution 45 asks that the Judicial Council review its opinion on charging interest on over-due accounts in view of current socioeconomic considerations.

A recommendation was adopted that Resolution 46 be referred to the Board of Trustees for inclusion in its continuing study of the JCAH. Resolution 46 directs the AMA to express

its concern to the JCAH about the value of the Quality Assurance Standards and suggests that the program be reevaluated with input from medical staffs practicing in representative hospitals. It also proposes that the JCAH hospital surveys be done jointly by physicians practicing in each state and that the AMA should continue to explore other means of improving accreditation methodologies.

As indicated in the Board of Trustees Report DD, all hospital accreditation standards will be rewritten. The

(Continued on next page.)

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Comments

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component report

The American Medical Association has urged component medical societies to become involved in or to actively form coalitions for health care which would include major businesses in the local area. The Denver Medical Society has been contacted regarding this kind of effort by the AMA. Prior to the Society's taking action, its Commission on Health Care Delivery has met with officials of the Institute for Health and the Colorado Health Care Coalition, which are already active in the Denver area.

Mr. Perry Warren, President of the Institute of Health described the program's beginnings as emanating from an October 1978 seminar on Health Promotion sponsored by the Gates Foundation. The Institute was funded by Gates and Coors Foundations as a research and development operation. It discovered early that a major problem was the absence of data, so made this one of the objectives of its existence, namely, creating its own data base, plus evaluating wellness programs and measuring their impact on health and cost containment. Currently, they are monitoring programs at Union Supply Co. (a small business), Cobe Laboratories, Inc. (1,600 employees), and Adolph Coors Co. (10,000 employees) hoping to ascertain the impact of structured wellness programs on absenteeism, utilization of health care, costs, etc.

An additional project is the development of a school health education curriculum to be integrated with the health education provided by pediatricians in their offices. Also, Mr. Warren spoke to a growing concern about the costs of health care for the retired population of businesses. For example, Gates Rubber Co. will have more retirees by 1990 than it has employees.

Speaking to the Commission from the Colorado Health Care Coalition were Mr. Fritz Ihrig, president, who is a vice-president with Samsonite Corp. and Mr. Virgil Blackburn, a systems engineer with IBM Corp., who is on loan from that company for one year to the staff of the Coalition. It is funded by participating businesses and industries which also includes Adolph Coors Co., Public Service Company of Colorado, Climax Molybdenum Co., Gates Rubber Co., Gates Forming Accessories, Inc., Denvamax Corp., the Colorado Association of Commerce and Industry, the AFL-CIO, and the Colorado Building and Construction Trade Council.

Some of the Coalition's objectives are:

A. Coordination

- To act as a control center for all health care system activities;
- To analyze and serve as a clearinghouse for health information;
- To be a legislative watchdog.

B. Financial

- To analyze health insurance benefit plans and restructure them to meet the specific requirements of a company;
- To promote the development of alternative health care delivery systems that include financial incentives to contain costs;
- To develop health costs information systems to promote competition among health care delivery systems.

C. Promotion

- To establish a Cost Containment education program;
- To support the development of

AMA Update, *continued.*

concerns expressed in Resolution 46 relative to the quality assurance standards should be given consideration in the rewrite.

Your Colorado delegation did support a proposal to allow direct membership in the AMA. This will now be possible, after the House considered a report from the Council on Long Range Planning that said there is a potential "market" of 241,000 physicians who are not members of state and county societies. There was a good, old-fashioned heated debate over this one, but the House did approve direct membership in AMA as a membership option and passed enabling amendments to the AMA bylaws. As state organizations are now structured, their membership dues are collected from October through the end of the year. The AMA recruiting of physicians would not commence until the following April, when AMA dues become payable, so there is a "semi non-competing" aspect to the direct membership.

As I noted, your Colorado delegation supported this move, since Colorado is presently one of the lowest in AMA membership of the 50 states. At the present time, the AMA has as members 38% of the practicing physicians and 47% of the total physicians in the United States.

It goes without saying that organized medicine needs, more than ever before, a strong national front, just as it does a strong, well-organized state effort on behalf of quality care provided by professionals. We, the delegation, think that this direct membership provision will have a positive effect on efforts of all organized medicine.

cost-effective medical technology;

To promote the development of employer/employee health education and wellness programs;

To support incentive legislation.

Re: H.B. 1523—Concerning an income tax modification for the mileage expenses of volunteers, and providing for a reduction of Federal adjusted gross income therewith...

H.B. 1523 provides Colorado taxpayers with a new deduction for the purposes of calculating their Colorado adjusted gross income. That deduction is constructed by the following elements:

1. *unreimbursed* mileage expense;
2. for *motor vehicle* use;
3. which is incurred without the person receiving pay or other compensation (*volunteer*);
4. from a *charitable organization* whose *sole purpose* is providing medical...care.

The deduction is not available if the expense is incurred for the purpose of lobbying. Furthermore, the deduction is not available if the taxpayer cannot prove a contemporaneous diary of expense has been kept.

The deduction should not affect our new reimbursement policy. CMS is not a charitable organization whose *sole purpose* is providing medical care. Therefore, the statute does not apply.

However, physicians who do volunteer work for a clinic or a foundation whose purpose complies with the statute may use this section to support an appropriate deduction.

In such a case there are two formulas available for the computation. The first is the difference between mileage allowance for state employees (\$.20) and mileage allowance authorized under section 170 of the federal tax code (\$.09), eleven cents per mile. The

second is merely a reflection of the mileage allowance for state employees, twenty cents per mile.

Waiting

A recent study conducted by the Department of Health and Human Services indicates that the average waiting period for patients in a physician's office is 29.4 minutes. The average patient wait for a physician in the emergency room was 38.2 minutes.

Consumer Price Index Summary of 1979-1980

Physicians congratulate yourselves. Your voluntary restraints indicate that regulation of fees is not a desirable public policy. The following chart illustrates this effort:

| | 1979 | 1980 |
|-----------------------|------|------|
| ALL ITEMS | 13.3 | 12.4 |
| ALL SERVICES | 13.7 | 14.2 |
| PHYSICIAN SERVICES | 9.4 | 11.0 |
| HOSPITAL ROOM CHARGES | 11.1 | 13.9 |

In 1980 the physician's services index and the hospital room charge index can be analyzed on a quarterly annualized rate to show the figures below:

| | JAN.-MAR. | APR.-JUNE | JULY-SEPT. | OCT.-DEC. |
|-----------------------|-----------|-----------|------------|-----------|
| PHYSICIAN'S SERVICES | 16.5 | 10.9 | 7.6 | 9.2 |
| HOSPITAL ROOM CHARGES | 17.9 | 6.9 | 16.0 | 15.1 |

Finally, a special index report of interest to all is the percent increase in the cost of energy. The figures are noteworthy.

| | 1979 | 1980 |
|--------|------|------|
| Energy | 37.4 | 18.1 |

If you calculate your waiting times the following patient satisfaction data may interest you:

- 30 minutes or less—satisfied patient
- 30 minutes to 60 minutes—moderate dissatisfaction
- 60 minutes or more—extreme dissatisfaction..

Drug Alert Bulletin: Legal Stimulants

A variety of pills and capsules are presently being widely distributed as safe, powerful stimulants and are available through mail order houses and local stores. These preparations are also being passed on the street as "speed" or "uppers". These formulations (black capsules, yellow capsules, blue and clear capsules, green and clear capsules, blue tablets, blue tablets with speckles, orange tablets, white tablets and white tablets with speckles) are designed as look-alikes to pharmaceutical-grade amphetamines and common street drug formulations. Although available from numerous distributors, most contain the same basic active ingredients: caffeine 100-200 mg, phenylpropanol-

mine 25-50 mg and ephedrine 25 mg.

Toxic syndromes very similar to amphetamine abuse syndrome have been reported with both ephedrine and phenylpropanolamine. Dietz (*JAMA* 245:601-2, 1981) described 7 patients who exhibited symptoms ranging from stimulation of the medullary respiratory center to tremor, restlessness, increased motor activity, agitation and hallucinations following ingestion of 50-75 mg of phenylpropanolamine. All side effects appeared within 1-2 hours after ingesting the tablet, and in 3 cases 200 mg of caffeine was taken concomitantly. Side effects generally subsided over the course of 2-4 hours. However, one patient required hospitalization for an acute psychosis that resolved over several days. Another patient had had a similar episode one year earlier after ingesting a similar agent. Herridge & Brook (*Br Med J* 2:160, 1968) described two patients

presenting with toxic psychosis and delusions associated with excessive self-medication with ephedrine. A 76-year-old man had taken up to 60 mg/wk for several years and a 57-year-old woman had taken increasing quantities of ephedrine over 20 years (up to 150 mg/day).

Hypertensive crisis in a 21-year-old female has been reported after ingestion of phenylpropanolamine 85 mg (DB Frewin et al, *Med J Aust* 2:497-8, 1978). Examination revealed a blood pressure of 190/120 mm Hg with symptoms of headache and vomiting. Although she had a family history of hypertension, the patient's blood pressure had been 90-110/60 mm Hg at recent physical exams. She received no specific treatment and within 5½ hours of her first complaint her blood pressure decreased to 120/70 mm Hg. Phenylpropanolamine has also been implicated as the cause of renal failure in a 28-year-old female

following 3 weeks of phenylpropanolamine as an appetite suppressant (W Bennett, *Lancet* 2:42-3, 1979). Ephedrine taken in doses sufficient to produce significant central nervous system stimulation also has significant cardiovascular effects, producing hypertension, tachycardia and ventricular arrhythmias.

Although phenylpropanolamine and ephedrine are widely available in over-the-counter preparations as either a nasal decongestant or bronchodilator, abuse potential does exist. When used in doses sufficient to produce significant CNS stimulation, cardiovascular effects are quite pronounced with the possibility of medical emergencies.

For further information regarding any of these preparations, call the drug consultation center at 893-DRUG in the Denver metro area or 1-800-332-6475 in Colorado.



Resident physicians from throughout Colorado listened to representatives of Conomikes, Inc., discuss the aspects of "Setting up a Medical Practice." This two-day workshop provided invaluable information to residents planning to go into private practice. CMS hopes to have another seminar in early-1982. Left, an instructor discusses the importance of writing job descriptions for the physician's office staff. Conomikes emphasizes that all employees should know exactly what their job entails and what is expected of them in their work.

The Air National Guard Needs You!

Bonnie Van Fleet
Assistant Director of Publications, Colorado Medical Society

What a peculiar statement for a woman to make! "The Air National Guard Needs You!"

What an experience to spend a day exploring a part of life which, heretofore, had been completely foreign to me. Being a woman (not totally liberated) and never having had the desire to be a combat or fighter pilot, I have not taken an interest in "weekend warriors." On that Saturday morning in April, as I drove through the gates of Buckley Air National Guard Base east of Aurora, I was preoccupied with the thoughts of grocery shopping. That's how a good part of my weekends were usually spent.

On arriving at Building 801, a huge hangar, I was met by a charming young man and young lady. They are typical of the National Guard ranks: full-time job during the week, devoting one two-day weekend per month to Guard duty. The young woman, Susie Rosamond, knows where her husband is when she's on duty; he, too, is a member of the Guard, and a pilot.

Brigadier General James C. Hall met me and escorted me through my day's review: the hangars where aircraft are constantly being checked, repaired, overhauled; the aircraft hooked up to monitors, their computers being thoroughly checked and calibrated (I never dreamed airplanes had computers). It was reminiscent of visiting an intensive care ward of the hospital where vital signs of the patient are being checked and charted every second of the way. General Hall said these fighter jets (they refer to them as A-7Ds, for some reason unknown to me) were constantly in a state of readiness, and could be at any combat zone in the world within 36

hours. This was MY AIR NATIONAL GUARD UNIT? These were my friends . . . my neighbors. I was impressed!

The insignia (the puma or cougar) of the fighter wing and squadron is prominently displayed on each plane with the Colorado flag. Some authorities would call this (painting our Colorado flag on the aircraft) defacing military property, but the flag is meaningful and important to the Guard members, so the flag goes where the aircraft goes.

One jet fighter seemed to call for

just one person to fly the plane. That's the way it struck me. No big deal! However, when you realize what a mammoth job it is to maintain one of these jets in a constant state of readiness, then you see where the Air National Guard needs many, many people. Maintenance requires between 15 to 20 ground support personnel for each jet fighter (there are 27 fighters in Colorado's unit). Typical records-keeping and other personnel needs require another five to ten people per craft. They all have to be fed, clothed, housed, transported, inoculated,



Colorado Air National Guardsmen Medical Technicians work in clean, well-equipped (though moderate) examination facilities in the Base Clinic.

given medical care AND proper training. When you add it all together, you can see why the Colorado Air National Guard has some 1,200 full-time or part-time people.

As I toured the rest of the base and looked in on the variety of jobs being performed, I learned about such things as "G-forces" (the force of gravity), life-support systems (pilot's flight suits and head gear, oxygen, pressurization, etc.), ejection seats, parachutes, high-speed/high-altitude ejection, tandem flights, the "Brain Bag," and many other previous unknowns. The "Brain Bag," by the way, is not a medical or physiological term. This refers to an information packet in the cockpit of each Guard fighter jet. Tandem flights mean that two planes always fly together, so that if one pilot gets in trouble, the pilot of the second craft pulls out the "brain bag" and starts a checkoff list, asking the pilot experiencing the trouble if he did this or that or such and such. Numerous serious situations are resolved without critical incidence. Life support systems are vital, and are checked, FULLY, each day. (I never knew there were so many different

kinds of flight helmets, either.)

For a unit with 1,200 or more persons involved, there are bound to be medical problems. That, in fact, was my reason for contacting the Colorado ANG in the first place. I wanted to know how many physicians were involved in this activity. So ... next stop: Base Hospital. Again, most of the people on the staff have totally different occupations in civilian life, but serve with the ANG because they like the change, want to learn, and are willing to serve and be paid for their time. One man, for instance, a machinist by trade, joined the ANG and was trained to become a medical lab technician. He's been at it for four years, and he enjoys every bit of his Guard duty. The base hospital is actually an in- and out-patient clinic, with good, necessary equipment for laboratory, X-ray and medical examination, dental facilities and 3 ambulances. In case of severe injury or illness, patients are transported to the Aurora Community or Fitzsimmons Army Medical Hospitals. Proper medical care requires physicians, and the Colorado Air National Guard needs two physicians now, be they

flight surgeons, pediatricians, orthopedic specialists, whatever; they need your knowledge and ability.

The ANG clinic is called an ATC, meaning air transportable clinic, and the personnel and gear can be picked up and air-lifted to any location to operate as a field hospital, capable of 99% out-patient care with operational supplies for a sustained 30 days. The unit did just such an exercise in each of the past four years in foreign countries.

What's in it (The Guard) for a medical doctor? Your rank (and your pay) will depend on your schooling, years in practice and age. You take one weekend per month (two days) and you are paid for four days. You are required to serve two weeks each year, for which you receive 36 day's pay. During these two-week summer tours you may find yourself in Spain, Panama, Italy (this year Canada), Greece, Holland, Turkey, anywhere in the world. Wherever you go you will be received with honor, knowing that you represent one of the finest such Air National Guard units in all the 50 states. Don't fret: Turkey is not on the duty agenda in the future; however, the Colorado ANG did participate in NATO exercises in Turkey for 30 days in 1979.

There are certain risks in belonging to the Guard: If you are now a physician in private practice, you do run the risk of being called to active duty. You also take the risk of being hit by a car every day of your life. I am sure there are a few physicians who would be concerned about the mortgage payment on the office or home, but the government makes allowances for this. If your unit is activated, the mortgage payments WAIT until you are back in private life.

Registered Nurses should not feel left out: The Guard needs your services, too, IF YOU'D LIKE INFORMATION, call Buckley ANG Base, and ask for the Recruiting Office.

My day with the Colorado Air National Guard was a real eye-opener. The people I met were friendly, interesting, knowledgeable and dedicated people. They believe in what they're doing. They can also use some help. My special thanks to Brigadier General John L. France, Colorado Adjutant General and Commander of the 140th Tactical Fighter Wing at Buckley; Brig. General Monroe G. Math-



MedTechs operate a complete, on-base laboratory for most routine tests. More complex testing is sent to Fitzsimmons Army Medical Center, located just two miles from Buckley ANG Base.

ias, Chief of Staff; Brig. General William Nuenes, Assistant Adjutant General; Brig. General James C. Hall, Director of Public Affairs; Colonel Stanley C. Wood; Colonel Jack Abercrombie; Lt. Colonel William Morris; enlisted personnel Larry Sutherland, Susie Rosamond, Chuck Johnson, Paul Ludwig, Archie Randall, Judy Cummings, John Candelaria, and the many others who were so kind and helpful. These are all people who have full-time pursuits, hopes and frustrations, just like you and me, but as members of the AIR NATIONAL GUARD, THEY WORK FOR ALL OF US!

When I left Buckley Field I had forgotten all about grocery shopping.

EDITOR'S NOTE: The Colorado Adjutant General is appointed by the Governor, and can be a member of either the Air or the Army National Guard. General France was ap-



All equipment in the Laboratory, as in other parts of the Clinic, is part of the ATC (Air Transport Clinic) which can be stowed for transport to any assignment area. Despite this on-call status, the ANG Base Clinic is complete and well staffed. Command Officers of the Colorado Air National Guard escorted Colorado Medicine's Bonnie Van Fleet through the Base facilities (below). Brig. General Monroe G. Mathias, Chief of Staff, Colo. ANG (left), and Brig. General James Hall, Public Information Officer, ANG (ctr). General Hall stopped to discuss some recruiting topics with M/Sgt. John Candelaria (behind Bonnie), chief of the ANG Recruiting Office.



pointed to the position upon the retirement of General Joseph Moffitt, long-time and highly-respected AG of Colorado. Various levels of Command Officers under General France in the Colorado ANG hold full-time positions in civilian life, and serve in the ANG on a voluntary enlistment basis. General Mathias is a Flight Captain for Continental Air Lines. General Nuenes is a Flight Captain for United Air Lines. Many of the fighter pilots are Flight Captains or Second Officers for airlines serving Denver. The Colorado Air National Guard is not only a combat-ready unit; it is a public servant in many areas of domestic life in our state, serving in search and rescue efforts, emergency medical service and transport, and many other functions of public safety and protection, always on call in any condition of emergency and environmental concerns, natural or man-caused disaster. Any questions you have are welcome. Call M/Sgt. John Candelaria, Buckley ANG Base, 366-5363. Physicians are needed!

Ask Me About Medicine

William S. Pierson
Director of Communications, Colorado Medical Society

During the past two years, the Colorado Medical Society has made great strides toward becoming a "proactive" force in organized medicine, rather than maintaining the "reactive" stance which has become the plight of so many physicians. Much of this positive change has been due to the increased participation by members in the affairs of organized medicine through their own federation.

For a number of years, the physician has been forced into a defensive posture because of the rash of malpractice suits, nuisance or otherwise, and has become very hesitant in talking freely to anyone about medical practice. This has happened, chiefly, as a result of the adversarial role of the public press, eager to become the voice of the "consumer" while losing sight of the scientific aspects of medical practice. Words or thoughts taken out of context have often "burned" the physician. Certainly, there have been justifiable incidents in which public rancor was expressed; however, the majority of situations in which the physician came off second best could have been avoided simply through effective communication.

Your Public Information Committee has proposed and instituted a program of "doctor communication" with the public, be they patients, press, politicians or just people. Realizing that the logical opposite of a defensive position is the offensive, the Committee asks that you, the physician, be well informed and appealing to your sense of medicine today. In so doing, the Committee is appealing to your sense of pride and accomplishment in your own profession and to speak out regarding those

issues of medicine which greatly concern the public.

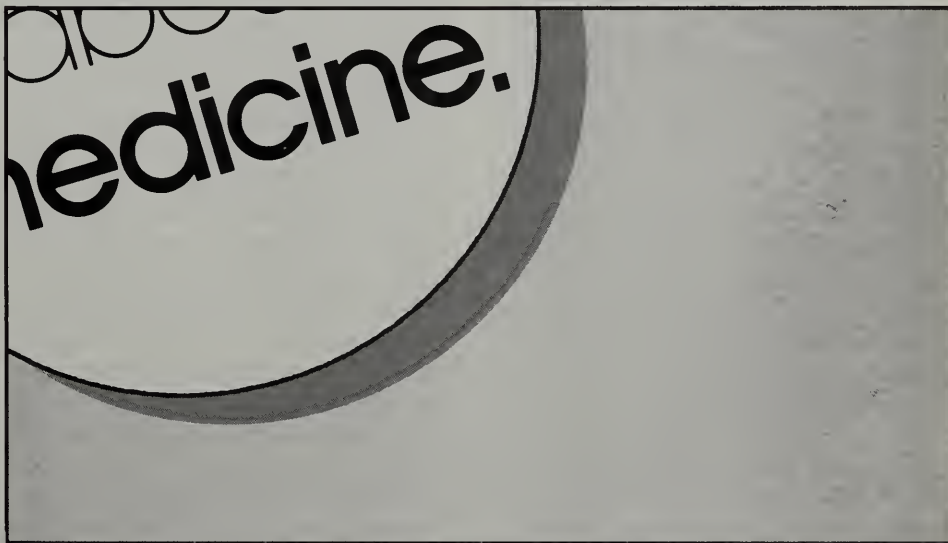
The program, "ask me about **MEDICINE**," is not a complicated or laborious one: If you are interested in your own welfare and that of your fellow professional, you can participate by writing to the Public Information Committee, Colorado Medical Society, 1601 E. 19th Avenue, Denver 80218, and say you want to be a part of this "AMAM" program.

It'll cost you one postage stamp to let the Committee know that you are interested. The rest will be done for you, and you will find that within a very short time you will be an extremely well informed medical professional who can speak to any subject of your profession (sans those medical specialty areas in which you do not practice). Be it an aggressive "investigative" reporter, or the nice lady who is concerned about her medical insurance costs, you'll be able to provide them the answers that are correct and necessary to your profession. Without question, the best spokesman for the medical pro-

fession is the medical professional. . . . YOU! Wouldn't you like to be able to supply the answers to the many burning questions about health care? Shouldn't you want to be a voice for your profession? If nothing else, wouldn't you like to be able to fill in some of the conversational gaps which occur among friends, at card parties or on the golf course? This program will help you do just that, and it will be one of the most valuable tools that organized medicine can possess.

Address your letter to AMAM, P.I. Committee, Colorado Medical Society, 1601 E. 19th Avenue, Denver, CO 80218.

Remember: you'll scarcely have to do anything. Just notify the Committee that you are willing to be a part of this program of pride and confidence. But YOU must ask to be a member. Writing that letter is important, it will give your fellow physicians the confidence of numbers. Let them know that you support the concept of physicians being "proactive" rather than remaining in the "reactive-defensive" position.



GMENAC Forecasts 38 % Increase in Number of Otolaryngologists by 1990 and Says That's About Right—But Is It?

William H. Call, M.D.
GMENAC Delphi Panel Member

The Graduate Medical Education National Advisory committee (GMENAC) released its final estimates last September 30 on the number of physicians who should be trained for each medical specialty.

GMENAC forecasts a surplus of 69,750 physicians by 1990. The Committee recommends tough measures not only to reduce the number of physicians but to redistribute the supply. It recommended a 10% reduction in medical school admissions by 1984 from 1978 levels, and that the government discourage the construction of medical schools. (The ten percent cut in entry class size, relative to 1978 enrollments would amount to reduction of 17.5% from the estimated 1981 class size.) If no measures are taken to reduce the number of foreign medical graduates entering practice in the United States, there will be an influx of between 40,000 and 50,000 in the next 10 years, which will account for more than half the estimated surplus of physicians.

The number of Neurosurgeons required will be 2,550 (450 fewer than were in practice in 1978), 11,600 Ophthalmologists (150 fewer than were in practice in 1978), 15,100 Orthopedists (3,250 more than were in practice in 1978), 2,700 Plastic Surgeons (100 more than were in practice in 1978). However, considering the number of residents in training in these specialties, there is projected to be a surplus of 11,800 General Surgeons, 10,450 Obstetricians, 4,700 Ophthalmologists, 5,000 Orthopedic Surgeons, 1,200 Plastic Surgeons, and 500 Otolaryngologists!

To reduce these anticipated surpluses GMENAC recommends that the Federal Government phase out capitation grants to medical schools

and end the requirement of large class sizes to qualify for such grants. It requests Congress to enact incentives for physicians to choose specialties GMENAC determines will be in short supply, which are Child Psychiatry, Emergency Medicine, and Nuclear Medicine. Scholarships should no longer be given to Americans studying medicine abroad. American graduates of foreign medical schools should face more stringent tests before being allowed to practice medicine in the United States. U.S. Citizens and aliens graduated from foreign medical schools should be required to successfully complete parts 1 & 2 of the National Board of Medical Examiners examination or its equivalent.

The "fifth pathway" for entrance into approved programs of graduate medical education in the United States should be eliminated, as should the transfer of U.S. citizens enrolled in foreign medical schools into advanced standing in U.S. medical schools.

GMENAC noted increasing numbers of nurse practitioners, physician's assistants, and nurse midwives will swell the total excess of people dispensing medical services. The Panel felt that the training of such professionals had not been properly evaluated and suggested "the need to train them at current rates should be studied in the perspective of the projected oversupply of physicians."

GMENAC recommended that the rate of entry into first year specialty training be reduced by 20% for the fields of General Surgery, Neurosurgery, Ophthalmology, Orthopedic Surgery, Plastic Surgery, Urology, and Colon and Rectal Surgery. It recommended a 10% reduction for Thoracic

Surgery. No change was recommended for Otolaryngology, the sole surgical specialty studied for which no reductions were recommended. However, if the reduction in resident numbers is achieved by the target date of 1984, the estimated surplus of specialists in 1990 will not be lowered, because the residents to whom commitments will have been made prior to 1984 will just be completing their residency programs. Only after 1990 will reductions in residency programs initiated immediately significantly reduce the numbers of specialties in practice.

Even the primary care fields, now felt to be in short supply, are forecast to be in oversupply by 1990 if current training trends continue. The supply of Family Practitioners will be 88,250—4,250 more than needed. The Pediatricians will number 37,750—7,500 more than needed. Internal Medicine specialists will number 73,800—3,550 more than needed. Despite this, GMENAC recommends that the graduates unable to obtain secondary care residency positions be channelled into primary care residencies.

The GMENAC report has received decidedly cautious and mixed reviews from the individuals and organizations which have commented so far.

In an editorial published in the *American Medical News* on October 3, 1980, the AMA apparently rejects the GMENAC recommendations: "We repeat our original concern: in the face of studies approaching the physician-supply problem from different perspectives and with differing methodologies, it is best to rely upon voluntary action and individual decision-making to solve the problem."

"An arbitrary government deci-

sion, based on flawed or incomplete information, could do great damage to society for years to come."

The AMA expressed accord, however, with recommendations to develop and implement procedures to assure that U.S. citizens receiving student or educational benefits are actually in attendance and to develop criteria to determine eligibility for U.S. citizens to obtain student loans and VA benefits for attending foreign medical schools.

Former AMA President and GMENAC Committeeman, Dr. Tom E. Nesbitt, stated, "I am firmly convinced that when we develop the necessary sophistication and the data bases we will be able to use the nation's tax resources for training physicians in a far more meaningful manner. Now is the time to refine the modeling process."

Bruce E. Spivey, M.D., a member of the GMENAC Modeling Panel, objected to GMENAC setting quotas based on inadequate, inaccurate data. "I am concerned that we are ascribing more to our model than I can be comfortable with . . . there will be a great loss of credibility because of recommendations that are not accurate . . . we have gone beyond what I think is a logical, defensible position in making specific recommendations."

The GMENAC report itself advises "that the numerical size of the aggregate estimates for 1990 is considered tentative until the methodology developed by GMENAC has undergone critical evaluation."

"Although the Committee has confidence in the designation of either a surplus or a shortage for a given specialty or subspecialty, the actual numbers derived from the models and contained in this report should not be interpreted literally. In view of the inevitable aggregate surplus of physicians in 1990, GMENAC recommends that the surplus be encouraged to enter the three primary care fields, once the shortages in other specialties have been corrected as much as possible. Larger surpluses should be created deliberately in the 1980s . . . the surpluses estimated for many specialties and subspecialties would be only partly corrected by 1990 even if residency training and those disciplines were completely discontinued."

To understand the reasons which caused the AMA and others to avoid endorsing the GMENAC Report, you should understand in some detail the method which the Committee used in making its forecasts. I was one of the Delphi Panelists for the Otolaryngology Advisory Panel for GMENAC. I will try to explain the method used and will illustrate it with some of the forecasts actually made, upon which the numbers estimate has been based.

A Delphi Panel is supposed to comprise a group of individuals so qualified by education and experience that they can forecast future trends in their areas of expertise. Usually, members of the Delphi Panel will individually make estimates and forecasts without knowing what the other Delphi Panelists are forecasting for a given problem. GMENAC, however, decided that the Delphi Panelists should meet face to face, and that the interaction between them would yield better estimates than the panelists were likely to make without the consultation of the others.

The Delphi process was further altered by including as panelists individuals who were not specialists in the medical specialty for which the forecasts were being made. All Delphi Panels included members of specialties and professions whose activities interacted with those of the specialty under discussion.

The Delphi process is a relatively new tool for forecasting. A review conducted by questionnaires sent to individuals who had either directed Delphi panels, participated on them or were familiar with the method, appeared in 1977. Three hundred twelve individuals responded. The authors reported that the Delphi method had been successful in identifying the major ramifications of significant technological breakthroughs, but that *Delphi studies had not in general been used as the sole input for forecasting, policy making, decision making or other applications due to a lack of total confidence in the method*. The authors also noted that "those project directors who had conducted two or more Delphi studies in the same substantive field believed that while the Delphi method has been a significant development they felt it to have been considerably less significant development than

those project directors who had only conducted one Delphi study in a particular field." "A majority of respondents felt that the Delphi method should generally be used in conjunction with another formal method, and 25% of the project directors felt that the Delphi method should never be used independent of other methods." "Overall, it was felt that other formal methods should precede, parallel and follow the Delphi method."

The GMENAC Committee did not conduct any parallel study using another method. If others who have used the Delphi process are to be believed, this failure is a fatal flaw in the study.

The "modified" Delphi process raises many serious questions. Nowhere in the GMENAC report, nor in its supporting documents, are there any references to previous use of a "modified" Delphi process in predicting. The American Council of Otolaryngology-Head and Neck concluded that the lack of such references indicated a lack of fundamental data on the method. It is one thing to conduct a pilot study on a topic using an untried method, but it is quite another to attempt to guide the United States government in the regulation of the numbers and specialty distribution of physicians by use of a method that has *no history of proven validity*.

The "modified" Delphi process allows group interaction, which is denied the original Delphi process. What can we expect from such group interaction, and how will such interaction affect the predictions of the panel? The Otolaryngology Delphi panelists observed several such group interactions which have affected the projections made by the panel as a whole.

Not only are there no data on the accuracy of predictions of Delphi panels, there are no data on the precision of such panels. (The difference between these two terms in the mathematical sense is as follows: accuracy refers to the ability of a method or procedure to correctly predict the outcome of a group of circumstances or actions. Precision refers to the internal consistency of the method to yield the same result each time when the same inputs are given to the process.) There are no data to determine

the precision of the Delphi process. Such data could have been obtained if GMENAC had run several parallel blind Delphi panels in one or more of the specialties to which the method was applied. The Amercian College of Surgeons and the American Council of Otolaryngology-Head and Neck Surgery felt that this method of prediction is most imprecise, and that, before its results are applied, its precision must be verified by presenting new panels the data that old panels have been given to see how closely the results agree.

The Modeling Panel freely manipulated the data and the conclusions of the Delphi Panels. These manipulations, we felt, further added uncertainty to the accuracy of the estimates.

The American College of Surgeons opened, "the fact that GMENAC did not express its projection as ranges and did not explicitly state the standard of deviation or degree of confidence for point estimates makes it impossible to judge the accuracy of the projections."

I suspect that no statistician could have constructed, from the data sets the Delphi panelists were given, a meaningful estimation of the standard deviation of error for the data sets. Lacking this I am reasonably sure no statistician could have projected standard deviations for the data sets taken as a whole. Lacking any data on the accuracy and precision of modified Delphi panel projects, statisticians cannot estimate standard deviations of error for this method.

The Otolaryngology Panel included the following specialties in addition to the five Otolaryngology Panelists: a Family Practitioner, Pediatrician, Audiologist, General Surgeon, Internist, Plastic Surgeon and an Oral Surgeon. All twelve were asked to estimate the incidence of the major diseases seen by Otolaryngologists, the incidence of these diseases in 1990, the percentage that should see a physician and the percentage of those who should see an Otolaryngologist. Similarly, estimates were made for virtually all the procedures in Otolaryngology, their incidence at present, in 1990, and the percentages of various types of procedure that should be done by an Otolaryngologist rather than some other specialist. Additionally, the Panel was asked to

estimate the number of hours that would be actually required to conduct a surgical case from the point of initial interview through the final postoperative visit. The length of time estimates were made for all procedures performed with any frequency by Otolaryngologists. For each parameter the median of the panelists' estimates was reported. Data bases were supplied by GMENAC.

The Otolaryngology Delphi panel comprised five panelists who were specialists in Otolaryngology and eight individuals from specialties which overlapped ours to some degree. The Otolaryngologists were "outvoted" on their own panel. We had among our Otolaryngology panelists a couple of articulate, forceful speakers, who carried the day with the non-Otolaryngologist panelists (who appeared overwhelmed by being asked to predict the specifics of an otolaryngologist's day, with which they were totally unfamiliar). This skewing of the results was further accentuated by the method of throwing our projections that deviated widely from the median, and when they did, they were thrown out in favor of the projections made by

**"...this process
should not be used
in forecasting
for the time being."**

those unfamiliar with Otolaryngology who were "tagging along" with the most vocal members of the group. The panel felt that the group dynamics within the Otolaryngology Delphi panel, plus the practices of discarding the estimates which deviated from the median and allowing equally weighted votes for those unfamiliar as for those familiar with Otolaryngology, have markedly vitiated, if not totally destroyed, the principles of the Delphi method.

The data the panelists were provided came from several sources: The

National Ambulatory Medical Care Survey (NAMCS), 1975; the Health Interview Survey: United States-1977 (HIS); the Hospital Discharge Survey (HDS); and the Society on Surgical Services for the United States (SOSSUS) 1975 Study.

None of these studies uses data collected more recently than 1975, and some data was collected as long ago as 1971. All of these studies use the ICDA Index, an index which has since been abandoned because of its inadequacies in grouping diseases appropriately. The ICDA Index grouped diseases which were unrelated to each other. For example, the ICDA Index C 384.0 included labyrinthine suppuration, rhinosalpingitis and salpingitis of the eustachian tube. ICDA Index C 387.9 included the diseases of the eustachian tubes as well as ossicular necrosis, perichondritis of the ear, and degeneration of the acoustic nerve. The panelists protested that such groupings made virtually impossible to make projections since diseases of varying incidence, morbidity, and prognosis were lumped together. However, no other methods were advanced by GMENAC to make such estimates, and the Panel used the lumped data it had under protest.

The Panel also protested the use of HIS data, because the HIS diagnoses were coded by nonphysicians. Independent studies have indicated that a diagnosis or procedure coded by a nonphysician is incorrect in somewhere between 25% and 35% of cases. No estimation of the uncertainty generated by this known error in recording has been made.

The authors of the HIS study also noticed systematic underreporting of hospitalizations by those interviewed. They estimated the underreporting to be less than 5%. These authors also noted the limited accuracy of diagnostic and other information collected from household interviews. The interviewee could usually pass onto the interviewer only the information he had obtained from his physician. For conditions not medically attended, diagnostic information was no more than a description of symptoms from which the interviewer made a diagnosis.

The data sets from all of these studies showed large relative standard errors. The incidence rate figures

often carried a relative standard error greater than plus or minus 30%. This means that there was a 35% chance that the actual incidence lay outside the given figure by more than plus or minus 30%. Such a wide range of error should give caution to making projections on the basis of such data. The Hospital Discharge Survey also excluded military and Veteran's Administration hospitals, where much ENT work is done.

The authors of the NAMCS Survey stated that they had not attempted to determine the systematic bias in their data but felt that there probably was systematic bias in the direction of underreporting the total number of office visits. The amount of underreporting is unknown, and therefore the amount of underestimation that the Panel made is likewise unknown.

The panelists became more uneasy about the accuracy of the data provided them when they noted the incidence of chronic sinusitis was estimated to exceed the incidence of acute sinusitis by 10 times according to the HIS data, by three times according to the NAMCS data and by 6 times in the HDS data. The NAMCS data gave an incidence rate for hay fever one twentieth as great as a study specifically designed by allergists to determine the incidence rate. There were numerous other instances in which the estimates of the various studies varied widely from one another or appeared unrealistic according to the experience of the panelists.

The SOSSUS data on surgery rates for procedures done by Otolaryngologists produced some interesting data. The SOSSUS study indicated that only 67% of mastoidectomies and only 68% of radical sinus surgery were performed by Otolaryngologists. No one on the panel could agree that other specialties were doing 33% of the mastoidectomies and 32% of the radical sinus surgery!

Because the Otolaryngology Panel felt that the data sets provided them for estimation purposes contained large standard deviations of error, inestimable systematic errors, and gross inaccuracies produced by grouping dissimilar conditions together, they wrote the Chairman of GMENAC, Dr. Alvin R. Tarlov, protesting the use of such data. We received reassurances about the adequacy of

the data from the support statisticians provided us, but we received no reply from Dr. Tarlov or the GMENAC Committee itself.

The Panel estimated that 85-90% of tonsil and adenoid surgery would be done by Otolaryngologists in 1990, (slightly more than 50% are estimated to be done by this specialty currently). The Panel did not forecast any further reduction in the incidence of this procedure, despite a well documented significant decline in the number done per year over the past decade.

The Otolaryngology Panel defended the idea that Otolaryngologists will do a substantial amount of primary care of head and neck complaints in 1990. If this be true, it will be in the face of increasing competition from all of the primary care specialties and probably from some of the over-supplied surgical specialties as well.

The GMENAC estimation process involved what was called a "needs-based" model, which viewed manpower requirements as a function of the number of medical services that *ought* to be consumed and of the number of providers that experts believe *ought* to provide it. For this method to be valid, the means must be at hand to assure providers the proper referral patterns which will guarantee that they do see all of the patients with these illnesses. The financial means for patients to seek services must be available. All the patients needing services must indeed seek them. Virtually all previous studies which projected medical manpower needs have used a demand-based model: projecting the current demand for services into the future and adjusting it for changes in population and age mix. If the access assumed by the needs-based model is not actually present in 1990, the manpower estimates will be high by an amount equal to those individuals who do not seek services or do not seek services from the intended specialist.

The estimates produced by the Delphi Panels were altered by the Modeling Panel, and in some instances the conclusions of the Modeling Panel were altered by the GMENAC Committee itself.

The estimates of the Otolaryngology Advisory Panel, when it emerged from the mathematical process de-

scribed in detail in the Report, was that 11,620 Otolaryngologists would be needed in 1990. The Modeling Panel, through methods not fully described in its committee meetings, revised the estimate downward to 8,000. The Modeling Committee reported that several specialties claimed the lion's share of several diagnostic categories, particularly otitis externa, otitis media, and upper respiratory infections. When the data was assembled for various specialties which handle these diseases, the total estimates exceeded 200% of the business. For instance, the Pediatricians felt that 100% of otitis externa cases should be seen by the Family Practitioner or the Pediatrician. The Otolaryngology Advisory Panel estimated that otolaryngologists would see 35% of such cases. The Modeling Committee reduced each specialty's estimate of the fraction of such diseases they would handle by a proportionate amount.

The American Council of Otolaryngology-Head and Neck Surgery concluded that the projections made by GMENAC for the need versus supply of physicians in 1990 and beyond are invalid due to the highly subjective and statistically unproven nature of the method used to arrive at the projections.

Although it may be possible to obtain better data sets for future Delphi Panels, the complete lack of information indicating the precision or accuracy of the Delphi process leads us to conclude that this process should not be used in forecasting for the time being. GMENAC itself, if it continues to be committed to a Delphi process, should be disbanded.

The recommendations of GMENAC should not be used by government or other agencies to alter the total number or mix of residencies available.

The American Medical Association and the American College of Surgeons have also rejected the GMENAC report.

In the meanwhile, if we object to the methods and conclusions of GMENAC, what better designed study can we as physicians propose and carry out?

Total Joint Arthroplasty of the Large Joints of the Upper Extremities

As Relief for Degenerative and Rheumatoid Arthritis

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In comparison with the publicity that has been given total joint replacement of the hip and knee, the shoulder, elbow, and wrist have received little attention. It seems only natural that the same basic principles that apply to the knee and hip replacement should be applied to the upper extremity.

The metal-polyethylene-methylmethacrylate total joints that do so well in the hips and knees should do as well in the upper extremity because they will not have to sustain the strong weight-bearing forces to which the knees and hips are subjected. Why then, are there so few upper extremity total joint replacements? The answer comes when we remember the natural course of the disease in these joints and the results of treatment other than joint replacement.

The upper extremity joints are not subjected to as much constant pressure. They can be protected by splinting. They do not suddenly collapse as a weight-bearing joint might, and may be functionally replaced by adjacent joints if they are essentially unaffected. For example, shoulder rotation can be compensated for by forearm rotation; and elbow flexion by wrist flexion. The patient, therefore, will often tolerate the bad joint if the adjacent joints are relatively unaffected or if the contralateral extremity is not appreciably involved.

The results of non-operative treatment have been relatively effective. Splinting with lightweight, non-cumbersome splints, an occasional injection of steroid, physical therapy with exercises, ice, or ultrasound have quieted many upper extremity joints. Surgery before the total joint replacement era has also been effective.⁹ Synovectomy, acromionectomy, rotator cuff repair for the shoulder,³ fascial arthroplasty, or synovectomy and radial head resection in the elbow,¹⁰

synovectomy, proximal row carpectomy or arthrodesis of the wrist⁴ have all been effective. In spite of this, there remain some patients with severe destruction of their joints or who have had soft tissue reconstruction which has failed. These patients should be considered for total joint replacement.

The Shoulder

Basically, there are two types of total joint prostheses for any joint. These are the constrained type and the non-constrained type. However, one now also speaks of a semi-constrained type. In the shoulder the constrained device has been quite controversial and generally the results have not been as good because of loosening or dislocation if there is a wide range of motion.⁵ Post,¹⁴ however, has recently published his series on prostheses of his design which have had acceptable results after design modification. In general, we feel that the non-constrained prosthesis should be used except in the uncommon case where stability can not be established.

In 1974 Neer¹³ reported good results with hemiarthroplasties of the shoulder and Cofield⁵ reported satisfactory results in the Mayo Clinic series using the Neer total shoulder replacement.

In our office thirty patients have undergone replacement arthroplasties of the shoulder with twenty-two of these having greater than a two-year followup. Of the twenty-two shoulders, all had the Neer humeral prosthesis. Fifteen of these shoulders had a polyethylene component of one of two types inserted in addition. The first type had a specially designed subacromial spacer and was used in seven patients (Figure 1). The second type was the Neer glenoid component and was used in eight patients (Figure 2).

The subacromial spacer was used if there was



Figure 1. Neer Humeral Prosthesis with Subacromial Polyethylene Spacer.

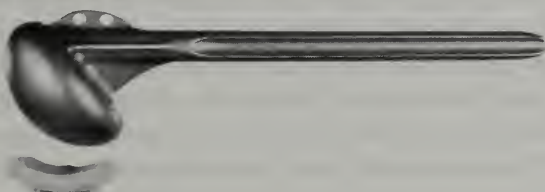


Figure 2. Neer Humeral Prosthesis with Glenoid Component.

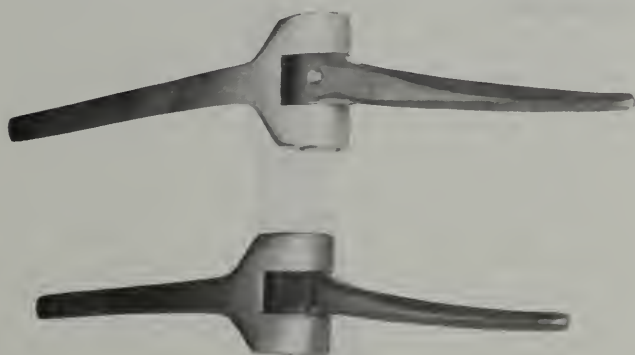


Figure 3. Hinge Type of Total Elbow (Coonrad Type).



Figure 4. Non-Constrained Total Elbow (Ewald Type).

an irreparable rotator cuff tear, with the reasoning that the deltoid would substitute for the rotator cuff if it could be brought under more tension. The glenoid component has been added to the recent shoulder replacements because of the erosive effect to the glenoid found in two of the shoulders studied for over five years. Although the subacromial spacer and glenoid components are compatible in the same shoulder, we have not used them together.

Good relief of pain was consistent throughout this series with nineteen of the twenty-two having only mild or no pain two years after surgery. There was one failure because of recurrent dislocation. This was in a patient in whom the spacer was used. Function was graded by assessing the ability to perform ten functions from combing hair to participation in non-violent sports. A one hundred point scale was designed and postoperative function compared to pre-operative. This group of shoulder replacements averaged thirty-three points pre-operative and jumped to seventy points post-operative.

Although pain relief and function improvement were impressive, range of motion improved only slightly with the total shoulder. Increases of an average of twenty-three degrees in elevation and eleven degrees of external rotation and four degrees of internal rotation were seen.

Elbow

Perhaps the most controversial of the three joints covered here is the elbow. There have been numerous reports of total elbow arthroplasties with frequent recall for revision of the prostheses. The original elbows were pure hinge joints. These had a high incidence of loosening. The rigid hinge has been replaced by the "semi-constrained" prosthesis. Examples of the total elbow are the Coonrad (Figure 3), Mayo, and Pritchard-Walker although many other types of constrained and semi-constrained have been developed.

The second type of elbow replacement is the non-constrictive type such as Ewald (Figure 4) or London. These, like other non-constrained joint replacements depend on ligamentous integrity of the elbow.

How good are these elbows? Coonrad⁷ reported a study of 150 elbows done at various centers around the country. There was a 12 percent incidence of loosening of the humeral stem but only six failures. He stated 95 percent were good in

rheumatoid arthritis but not good for trauma. Cofield, Morrey, and Bryan⁶ reported fifty Mayo elbows and thirty-five Coonrad elbows, and found similar results with these two elbows but reported only 51 percent and 56 percent good results respectively. Ewald⁸ reported sixty-nine of his elbows in 1978 with 10 percent revisions, no loosening, but five had recurrent dislocations. Clark and Weiland² presented seventeen Ewald elbows all with relief of pain, but they again mentioned the problem with subluxation although only one in this group required a revision because of the subluxation.

In our series of total elbows, we have used eight Ewald, three GSB constrained hinges, and one Coonrad elbow, all for rheumatoid arthritis. The first elbow, a GSB hinge was inserted in 1971 and remains an excellent result. The four hinge elbows have an average range of motion of 120 degrees. None of them have loosened and all are excellent results. The eight Ewald elbows have a range of motion of 110 degrees. One was a failure due to infection. This elbow was converted to a resection arthroplasty. None loosened. Two of the eight sublux on occasion but these are painless and the patients have learned to control the subluxation by avoiding stressful positions. Except for the one failure, the remaining seven are painless.

Wrist

The wrist is the key joint in the upper extremity and a stable, balanced and painless wrist is necessary for proper function of the upper extremity. A fused wrist fulfills this criteria, but in the patient with multiple upper extremity deformities some wrist motion can be very important. The most common type of implant used in the wrist is the Swanson silicone device. This is similar but larger than the ones used in the finger joints. It is not truly a total joint prosthesis but a spacer used before encapsulation takes place. Like the shoulder and elbow, prostheses have been developed with the Meuli^{11, 12} and the Volz^{11, 15} being used most frequently. In 1977, Beckenbaugh and Linscheid¹ reported twenty-six Meuli wrist arthroplasties. Nine of these required re-operation but after the second surgery, 77 percent of the total group had excellent or good results. The most common problem was failure to balance the wrist properly at the time of the surgery. This problem is also seen in the series of Volz wrists.^{11, 15}

In our clinic, we have used the Volz total unit. This prosthesis is non-constrained and allows ninety degrees of flexion-extension and fifty degrees radio-ulnar deviation. The distal component was first introduced with two prongs, one to be cemented into the second metacarpal and the other into the third. More recently, a single pronged component to be placed into the third metacarpal has been found to better approximate the normal axis of motion and has replaced the two prong component. The proximal component is polyethylene lined and is cemented into the radius. We have performed and carefully analyzed twenty-two Volz total wrist arthroplasties. Twenty of these were for rheumatoid arthritis. The average followup was eighteen months. A careful analysis of these twenty patients revealed that 75 percent had good or excellent results and that balancing was the greatest problem. The wrists tend to go into flexion and ulnar deviation unless the forces are negated by proper placement of the components and soft tissue reconstruction. In one patient, revision was needed after two years because of loosening of the distal component.



Figure 5. Volz Total Wrist.

Discussion

Replacement arthroplasty of the upper extremity has gained acceptance with results approaching those of total knee arthroplasties for relief of pain. The number of patients, however, needing the upper extremity operations is much smaller. There are some similarities between the upper and lower extremity implants, and the upper extremity surgery has gained much from the extensive investigation of total hips and knees. The facts that constrained prostheses will loosen quicker than non-constrained ones, that the elbow like the knee is not strictly a hinge joint and replacing one of the joints with a hinge is bound to fail sooner or later have been learned. Methods of cement and metal fixation, the wear of metal on polyethylene, the cement-bone interface, prevention of infection, and the type of prophylactic antibiotics have also been borrowed from the work with total hips and knees.

Certain similarities between the upper extremity arthroplasties can also be found when we study the results. Good results can be expected in rheumatoid arthritis. The results in traumatic joints are unpredictable, and we do not advocate use of the implants in this type of joint. The non-constrained joints have the disadvantage of pos-

sible instability and capsular reconstruction must be part of the operative procedure. We feel, however, that the incidence of loosening and final failure will be much less with the non-constrained joints. The upper extremity joints have not been widely accepted. They are difficult to put in properly, and since there are fewer patients who need them, the average orthopedic surgeon will infrequently see a patient who may benefit from such a procedure and only an occasional surgeon will have the expertise from a larger number of patients.

Summary

Replacement arthroplasties of the large joints of the upper extremity have been ignored in comparison with total knee and total hip arthroplasties simply because the number of patients who could benefit from these procedures is small. The results with total shoulders, elbows, and wrists, however, approach those of total knee arthroplasty for relief of pain. These procedures are strongly recommended for rheumatoid arthritis. Our results with twenty-two Neer shoulders, twelve elbow replacements, and twenty-two Volz wrists are presented here and confirm this recommendation. ●

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Infective Tricuspid Valve Endocarditis

Associated with a Secundum Type Atrial Septal Defect*

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The eighth case of infective endocarditis associated with an isolated atrial septal defect of the secundum variety is reported. A 63 year-old man developed involvement of the tricuspid valve without evidence of systemic embolization. The clinical presentation and surgical findings are discussed, and the importance of considering endocarditis in patients lacking typical manifestations is emphasized.

Introduction

The association between infective endocarditis and an isolated atrial septal defect of the ostium secundum type is rare.¹⁻³ In addition, the diagnosis of right-sided endocarditis may be more difficult when only limited clinical features are present.^{4, 5} We report a patient with endocarditis involving the tricuspid valve and briefly review the literature.

CASE REPORT

A 63 year-old man was admitted on March 26, 1977 for evaluation of a cardiac murmur and a 15-pound weight loss over the preceding six months. Thirty years before admission, he consulted a physician because of shortness of breath. He was told of a cardiac abnormality and subsequently had had intermittent periods of shortness of breath, orthopnea, and dependent edema responsive to diuretic therapy. No history of rheumatic fever was elicited.

A number of syncopal episodes had occurred, and four months prior to admission he was evaluated for these at another hospital. He had also begun to have chills during that time but was discharged in three days without specific diagnostic findings. Several

days before entry, he again returned to the same hospital for evaluation of chills and a protracted episode of palpitation. He was placed on digoxin, nitrates, procainamide, and ampicillin, and transferred for further evaluation.

The temperature was 100.6°F orally; blood pressure 100/70 mmHg; and pulse 110 beats per minute. On examination, the nail beds were dusky. The skin, conjunctivae, and oral mucosa were clear and fundi unremarkable. Jugular-venous pressure was not elevated and the carotid pulses were forceful and symmetrical. Lung fields were clear. The precordium was active. The first and second heart sounds were increased in intensity and definite splitting of the second sound was not appreciated. A short, grade 2/6, early systolic murmur was heard over all areas of the precordium. At the lower right sternal edge an early, grade 1/6, diastolic murmur was heard. The liver and spleen were not enlarged. Peripheral pulses were intact with no brachio-femoral lag. There was no edema.

Roentgenogram of the chest showed marked cardiac enlargement, a small aorta, massively enlarged right and left pulmonary arteries, and a right basilar infiltrate possibly representing a septic pulmonary infarct (Figure 1). An electrocardiogram revealed atrial flutter with 2:1 atrioventricular block and a ventricular rate of 120, right axis deviation, right bundle branch block, and evidence of right and possibly left ventricular enlargement (Figure 2). In addition, an echocardiogram demonstrated marked right ventricular and left atrial enlargement, abnormal anterior movement of the septum during systole, and multiple echoes from the tricuspid valve leaflets with pansystolic sagging (Figure 3). The white blood count was 9,700 with 84% polymorphonuclear cells and 5% lymphocytes. The hematocrit was 43%. Electrolytes, creatinine, and bilirubin were normal. The clinical impression was that of an atrial septal defect of the secundum variety with possible pulmonary hypertension and reversal of the shunt.

During the three days following admission, he was intermittently febrile. On the fourth hospital day, he was afebrile and underwent cardiac catheterization and angiography. At study, the atrial defect was easily crossed by the catheter, and oxygen saturation data and hydrogen curves confirmed left to right shunting at the atrial level. Pulmonary blood flow was nearly three times systemic (pulmonary index 4.5, systemic

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Figure 1. Chest roentgenogram. Posteroanterior view showing marked cardiac enlargement with enlarged right and left pulmonary arteries and right basilar infiltrate.

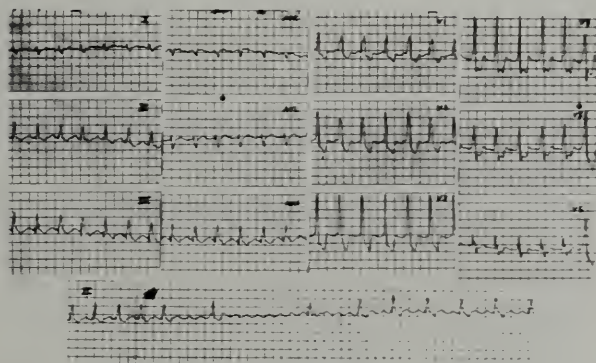


Figure 2. Electrocardiogram and rhythm strip (IMV=10 MM) showing atrial flutter, following carotid sinus massage (arrow), with 2:1 atrioventricular block, right bundle branch block, and evidence of biventricular enlargement.

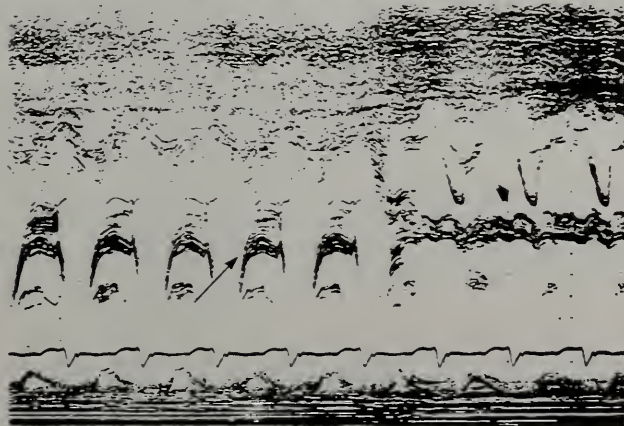


Figure 3. Echocardiogram demonstrating right ventricular enlargement with a normal appearing anterior mitral valve leaflet (thick arrow) and the multiple echo pattern from the tricuspid valve (thin arrow).

index 1.56). Pulmonary artery pressure was 50/30 mmHg with a right ventricular end-diastolic pressure of 9 mmHg. Systemic arterial PO_2 was 42 mmHg improving to only 64 mmHg with 100% O_2 inhalation for 10 minutes. On ventriculogram, the left ventricle was poorly contractile. The coronary vessels were free of significant obstructive lesions.

Planned surgical closure of the septal defect was cancelled when the patient again became febrile to 102°F. Five of eleven serial blood cultures over the ensuing ten days grew group D streptococcus, not enterococcus. Cultures of sputum and urine grew no pathogens. The white blood cell count remained normal and no evidence of peripheral embolization developed. Cardiac examination did not change and serial chest films showed resolution of the right basilar infiltrate. He was treated with intravenous penicillin-G, two million units every four hours, for four weeks with marked subjective improvement in his well being and no return of his fever. On May 10, 1977, he was taken to surgery where a 2x3 cm. typical secundum atrial septal defect was found. The margins of the defect were sharp and not grossly involved by endocarditis. Inspection of the tricuspid valve revealed multiple vegetations and distortion of the leaflets to such an extent that replacement was felt necessary. The septal defect was closed with a pericardial patch and the tricuspid valve replaced with a 35 mm porcine xenograft valve. Pathologic examination showed no inflammation or infection of the tissue excised from the septal defect margin. The tricuspid valve leaflets, however, revealed heavy fibrin deposition and acute and chronic inflammatory cells, with gram positive cocci. Specimen cultures of the minced valve were sterile. Post-operatively, the patient did well. The intravenous penicillin was continued for seven days following surgery and then was stopped without recurrence of his fever. He was discharged on coumadin and digoxin on May 24, 1977 and is well after four years.

Discussion

Congenital cardiac disease is the predisposing cause of less than 10 percent of cases of infective endocarditis.³⁻⁶⁻⁸ Of the congenital lesions, patent ductus arteriosus, ventricular septal defect, and tetralogy of Fallot are most commonly associated with endocarditis.⁶ In a review of the English literature, only seven well-documented cases of endocarditis associated with an isolated secundum atrial septal defect were found.⁹⁻¹⁵ Cases which were not included were those associated with underlying rheumatic valvular deformities,^{3, 16, 17} or those which were accompanied by parenteral drug abuse¹⁸ or followed cardiac catheterization within a period of four weeks.¹⁹ Others lacked definite clinicopathologic information.^{3, 14, 17, 20} The rarity with which secundum atrial defects are associated with endocarditis has been thought due to the lack of significant pressure gradients between the left and right

atria, preventing the venturi-jet effect seen in other congenital deformities more commonly complicated by endocarditis.^{6, 21} There was no involvement of the free edges of the septal defect in our patient; similarly, none of the seven previously reported cases was so involved.

In an autopsy study of 62 patients with interatrial septal defects, Roesler²⁰ noted the frequent occurrence of associated non-congenital valvular deformities. Okada and his group²² noted deformities of the mitral, tricuspid, and pulmonary valves in each of seven hearts studied with isolated secundum atrial septal defects. These changes were unlike typical rheumatic or infective deformities and were attributed to proliferative and degenerative responses secondary to mechanical stresses associated with the altered flow patterns present with atrial septal defects. Furthermore, they showed that high shunt flow with relatively low right ventricular pressure, as demonstrated by our patient, was associated with the most extensive fibrosis of the tricuspid valve, while in the presence of high right ven-

tricular pressure and relatively low shunt flow significantly less tricuspid valve thickening occurred. Thus, there is good evidence that the tricuspid valve is abnormal in patients with atrial septal defects and one wonders why this abnormality is not associated with an even higher incidence of infective endocarditis.

In addition to the infrequent occurrence of endocarditis with an atrial septal defect, the clinical consideration of endocarditis may not be made in the older patient. In one series,²³ the diagnosis of endocarditis was not initially suspected in 60 percent of patients with endocarditis over sixty years of age regardless of which side of the heart was involved.

Furthermore, the initial blood cultures were sterile in our patient emphasizing the observation that antibiotics empirically administered may make the diagnosis of infective endocarditis unnecessarily difficult. This diagnostic difficulty is especially pronounced when dealing with a lesion so rarely complicated by endocarditis as an atrial septal defect of the secundum variety.

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ACKNOWLEDGEMENT

We are indebted to Miss Cyndi Lesser for technical assistance.

CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

August

3-6 **24th Annual Pediatrics Postgraduate Course.** Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241.

3-6 **Gynecology.** Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, C-295, Denver 80262. (303) 394-5241.

7-9 **Marriage and Divorce Counseling in Medical Practice:** A workshop to be held at the Sheraton Santa Fe, in New Mexico. Course is acceptable for 13 elective credits by the A.A.F.P. Contact: Dr. Thomas M. Pick, 474 Main Street, Greenfield, Massachusetts 01301; Tele: (413) 774-2889.

9-13 **Perinatal Medicine.** Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. 394-5241. (21 hours of AMA Category 1 credit).

10-13 **Perinatal.** Snowmass, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Avenue, C-295, Denver 80262. 394-5241. (21 hours of AMA Category 1 credit).

10-14 **Aspen Conference on Pediatric Disease, 1981 - Tumors.** The Gant, Aspen, Colorado. Contact: J. Thomas Stocker, M.D., Department of Pathology, The Children's Hospital, 1056 East 19th Avenue, Denver 80218. 861-6712. (27 hours of AMA Category 1 credit).

14-15 **Use of the CO₂ Laser in Gynecology.** Beth Israel Hospital, 1601 Lowell Blvd., Denver. Contact: Beth Israel Conference and Institute Program, P.O. Box 11366, Denver 80211. (303) 629-5333. (12 hours AMA Category 1 Credit. Applied for 12 ACOG Cognates).

14-18 **Primary Care Orthopedics.** Aspen, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303) 394-5241.

19-22 **The Kidney in Systemic Illness: Malignancy, Pregnancy and Connective Tissue Disease.** The Given Institute of Pathobiology, Aspen, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver 80262. (303)

394-5241. (16 hours of AMA Category 1 credit; 16 hours of AAFP credit).

20 **Anemia Work-Up.** Vail, Colorado. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80203.

28-29 **Rheumatology - A Postgraduate Clinical Experience:** Sponsored by the Joe and Betty Alpert Arthritis Treatment Center, Rose Medical Center, Denver. Contact: Dorothy M. Bailey, Office of Education, Rose Medical Center, 4567 East 9th Ave., Denver 80220. Tele: (303) 320-2102. Category 1 credit & AAFP Prescribed Credit Offered. Fee: \$125.

29-31 **Tutorials in the Tetons: Clinical Cardiology · Diagnostic and Therapeutic Advances.** Jackson Lake Lodge, Grand Teton National Park, Moran, Wyoming. Contact: Mary Anne McInerney, Extramural Programs Department, American College of Cardiology.

September

3-5 **29th Annual James T. Waring Chest Conference.** Longs Peak Inn, Estes Park, Colorado. Contact: Tony Marostica, American Lung Association, 1600 Race Street, Denver 80206. (303) 388-4327. (10 hours of AMA Category 1 credit).

4-6 **Pediatric Neurology Mini-Course.** Keystone Resort, Colorado. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Avenue, Denver 80218. (303) 861-6949. (AMA Category 1 Credit available).

10 **Controversies in the Practice of Pediatrics: ongoing.** Sponsored by The Children's Hospital, Denver; Department of Pediatrics, University of Colorado, Health Sciences Center. Held at various locations. AMA Category 1 = 6 hours per session. Contact: Health Education Department, The Children's Hospital, 1056 East 19th Avenue, Denver 80218; Tele: (303) 861-6949. Fee: \$45.00.

17 **Neonate Conference:** sponsored by American Lung Association of Colorado. Conference to be in Alamosa, Colorado, conducted by The Children's Hospital in Denver. Contact: American Lung Association, south region, 119 West 6th, Pueblo, Colorado 81003; Tele: (303) 543-LUNG.

25-26 **9th Annual Phelps Pulmonary Conference,** at the Don K Ranch, near Pueblo. Contact: American Lung Association, South Region, 119 West 6th, Pueblo, Colorado 81003; Tele: (303) 543-LUNG.

25-26 **The Medical Consequences of Nuclear Weapons and Nuclear War:** sponsored by The Department of Medicine, University of New Mexico and Physicians for Social Responsibility. To be held at the Regent Hotel in Albuquerque. (9 hours). Contact: Linda Taylor, New Mexico Physicians for Social Responsibility, P.O. Box 4096, Albuquerque, New Mexico 87106; Tele: (505) 262-1862.

25-26 **10th Annual Montrose Fall Clinics.** Contact: Kathy Holman, Montrose Memorial Hospital, 800 South Third St., Montrose, Colorado 81401; Tele: (303) 249-2211. 10 CME hours.

27-30 **Sports Medicine Now:** sponsored by The Department of Family Practice & the Office of Continuing Education of the School of Medicine at the University of California, Davis, in cooperation with University Extension. Site: Stanford Sierra Lodge, Fallen Leaf Lake (South Lake Tahoe), California. Tuition: \$200 M.D.s; Credit: 22½ hours of Category 1 credit. Contact: Ardi Neiswonger, Publications Representative, Office of Continuing Medical Education, School of Medicine, University of California at Davis, Davis, CA 95616; Tele: (916) 752-0328.

October

5 **What You Should Know About Anticoagulants.** Burlington, Colorado. Contact: Martin Rubinstein, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80202. (2 hours of AMA Category 1 Credit; 2 prescribed hours of AAFP Credit).

5-9 **Clinical Management and Control of Tuberculosis,** at Denver; sponsored by National Jewish Hospital & Research Center/National Asthma Center, Denver. Course Director: Thomas Moulding, M.D.; 40 hours of AMA Category 1 credit, AAFP credit pending; registration fee \$300, \$150 for physicians in training. Contact: Shirley Maris, NJH/NAC, 3800 East Colfax Avenue, Denver 80206; Tele: (303) 388-4461.

10-11 **The Charley J. Smyth Symposium on Arthritic and Rheumatoid Conditions of the Upper Extremity.** The Fairmont Hotel. Contact: John A. Boxwick, Jr., M.D., 4200 East 9th Avenue, Box C-309, Denver. (303) 394-8718. (14 hours of AMA Category 1 Credit).

12-13 **South Dakota Perinatal Association Sixth Annual Perinatal Conference.** Holiday Inn, Spearfish, South Dakota. 9.6 hours credit applied for. Guest speakers include: Preston Dilts, M.D.; John Grossman, M.D.; George McCracken, M.D.; Lu-Ann Papile, M.D. Contact: Margo Varcoe, R.N., S.D.P.A., 1100 S. Euclid, Sioux Falls, South Dakota 57105; Tele: (605) 339-6578.

17 **Practical Applications of Allergy for Primary Care Physicians** at NIH, Bethesda. 6 hours of AMA Category 1 credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital, 3800 E. Colfax Avenue, Denver 80206; Tele: (303) 388-4461.

20 **SIDS — Sudden Infant Death Syndrome:** Sponsored by the SIDS Counseling & Information Center, The Children's Hospital, Denver. Held at Sheraton Inn, Airport, Denver. AMA Category 1 credit available. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Avenue, Denver 80218; Tele: (303) 861-6949.

20-25 **General Medicine.** Hilton Head Inn, Hilton Head Island, South Carolina. Registration Tuesday, October 20th - 4:00-6:00 p.m. Contact: Beth Israel Hospital, Conference Program, P.O. Box 11366, Denver 80211. Denver Metro Area: (303) 629-5333; Outside Colorado (800) 525-5810.

22, 23, 24 **The 12 Lead ECG for the Primary Care Physician:** Location: Presbyterian Hospital, Albuquerque, New Mexico, sponsored by the New Mexico Heart Institute. Fee: \$150.00. CME Credit: AMA Category 1 - 23 hours. AAFP - 23 hours. ACEP - 23 hours. Contact: Barry W. Ramo, M.D., (505) 242-2796.

30 **Round Robin Conference:** at Lamar, Colorado. Sponsored by American Lung Association of Colorado. Contact: Monica Ledesma, Tele: (303) 336-4343.

November, 1981

1-5 **88th Annual Convention of the Association of Military Surgeons in the U.S.** To be held at the Convention Center, San Antonio, Texas. The program will include continuing education offerings for physicians, dentists, nurses & many other disciplines. There are Meet-the-Investigator presentations, a major core Program, a Combat Medical Readiness Course, Seminars for Nurses, Dentists, Pharmacists, etc. Contact: Mr. T. A. Glasgow, Chief, Corporate Planning, HQ, Aerospace Medical Division, Brooks Air Force Base, Texas 78235; Tele: (512) 536-3656 or CDR T. G. McMahon, Asst. Exec. Director, AMSUS, P.O. Box 104, Kensington, Maryland 20795; Tele: (301) 933-2801.

3-4 **Symposium on Diet and Exercise: Synergism in Health Maintenance:** Lake Buena Vista, Florida (Walt Disney World Complex). AMA Category 1 Credit on an hour-for-hour basis towards the Physician's Recognition Award of the AMA. 13 Prescribed hours by the American Academy of Family Physicians. Fee: \$60.00. Contact: Department of Foods & Nutrition, American Medical Association, 535 North Dearborn St., Chicago, IL 60610; Therese Mondeika, R.D., Dept. of Foods & Nutrition, Tele: (312) 751-6524.

8-15 **Update in Clinical Endocrinology and Infertility:** Hilton Head Inn, Hilton Head Island, South Carolina. Registration Sunday, November 8. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver 80211. Tele: (303) 629-5333. Toll-free outside Colorado: (800) 525-5810.

35th Annual Rocky Mountain Cancer Conference

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Division of Clinical Oncology
Istituto Nazionale di Tumori, Milan, Italy

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Clinical Director, Joint Center for Radiation Therapy
Harvard Medical School, Boston, Mass

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(Continued on page 275.)

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(Continued from page 273.)

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obituaries

Dr. Alan A. Basinger, 59, died at 5:30 p.m. Sunday, May 31, 1981, at his home, from a heart attack. Dr. Basinger was a radiologist at St. Mary's Hospital since 1962. He had been head of the radiology department for 14 years and had continued an active practice after relinquishing that title.

Dr. Basinger was born in Cheraw and attended school there. He received his bachelor's degree from the University of Colorado and his medical degree from the CU medical school in 1947.

Dr. Basinger came to Grand Junction from Wheatridge, where he had been affiliated with the Lutheran Hospital. From 1955 to 1959 he had a private practice in Glenwood Springs.

He enjoyed breeding Arabian horses and he exhibited them at many horse shows.

He was a member of the Mesa County Medical Society and the Colorado West Arabian Horse Club.

Surviving are two daughters, Jan Williams of Fruita and Martha Basinger of New York; three sons, Jeff and Tom Basinger of Denver and Steve of Fort Collins; his mother, Mrs. Dovie Basinger of Denver, and four grandchildren.

Joseph L. Glaser, M.D., died at Rose Medical Center. Dr. Glaser, 65, was the former president of the Rose Medical Center surgery department. He was a 1941 graduate of University of Washington Medical School, interned in St. Louis City Hospital and did post-graduate work at Evanston Hospital, Northwestern University Medical School and the Denver Veterans Administration Hospital. He joined the staff at Rose Medical Center in 1948, and had served as a

member of the board of trustees at the hospital.

Dr. Glaser was a fellow of the American College of Surgeons, a member of the Colorado Medical Society, a member of the Denver Academy of Surgeons and a fellow of the Southwestern Surgical Congress. A Joseph L. Glaser memorial fund has been established at Rose Medical Center.

Henry W. Haig, M.D., of 925 Clayton Way, died Sunday, July 12. He was 74.

Dr. Haig was on the staff of St. Luke's Hospital. He had been a member of the American Medical Association and the Colorado Medical Society since 1943.

Dr. Haig was born Oct. 4, 1906, in Scotts Bluff County, Neb., and he graduated from the University of Colorado Medical School in 1934.

During his Medical career Dr. Haig was also a Fellow of the American Society of Abdominal Surgeons; Fellow of the International College of Surgeons; a member of Alpha Omega Alpha and Phi Rho Sigma medical fraternities; Denver Medical Club; Denver Athletic Club, Emulation Masonic Lodge 154, and the Cripple Creek Elks Club.

Survivors, in addition to his wife, Tillie, include a son, John Haig of Derby; a daughter, Julia Gaisser of Swarthmore, PA; three grandchildren; and five step-grandchildren.

Contributions may be made to Presbyterian-St. Luke's Community Foundation, 1805 Williams St., Denver 80218, or the American Lung Association of Colorado, 1600 Race St., Denver 80218.

John J. Rowe, Sr., 2250 Mariposa Avenue, died at Memorial Hospital June 28, 1981, of a heart attack. He was 63.

He was born April 3, 1918, in New London, Connecticut, the son of John and Mary Cashin Rowe. He married Marie Cardon in Washington, D.C. in 1942.

A self-employed pathologist, Mr. Rowe served with the U.S. Army in World War II in the South Pacific theater.

He came to Boulder from Cedar Falls, Iowa, in 1954, and lived at the Mariposa address for 20 years. He received his medical doctorate at Georgetown University Medical School.

He is survived by his wife of Boulder; four sons: John Jr. of Dayton, Ohio; George of Golden; Robert of Denver and Tom of Gainesville, Florida; a daughter, Beverly Marie Rowe of Salt Lake City; and two grandchildren.

Contributions may be made to the medical library of the school of the donor's choice.

Memorial services for **Dr. Anne Hoague Stewart**, 78, Virginia Beach, Va., a former Denver resident, will be in September at Virginia Beach.

Dr. Hoague was born March 17, 1903, in Worchester, Mass. She moved to Denver in 1952 to pursue psychiatric training at the University of Colorado School of Medicine. After completing her residency training she joined the faculty in the Department of Psychiatry.

While remaining on the faculty, she was in private practice in Denver and was also a consultant to many towns in western Colorado.

Dr. Hoague was a member of the American Psychiatric Association and the American Psychoanalytic Association.

She moved to Virginia Beach, where she was a faculty member of the Eastern Virginia Medical School and in private practice as a psychiatrist and psychoanalyst. She lived in Virginia Beach from 1976 until her death.

Survivors include a daughter, Mrs. Ann Poffinberger, Pittsburgh, PA; two sons, Dr. Charles Evanston, IL, and Dr. George, Sacramento, CA; a sister, Mrs. Constance Kaufman, Treadwell, NY; and a brother, Francis Hoague, Seattle, WA.

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colorado medicine

August, 1981

Volume 78, Number 8



Annual
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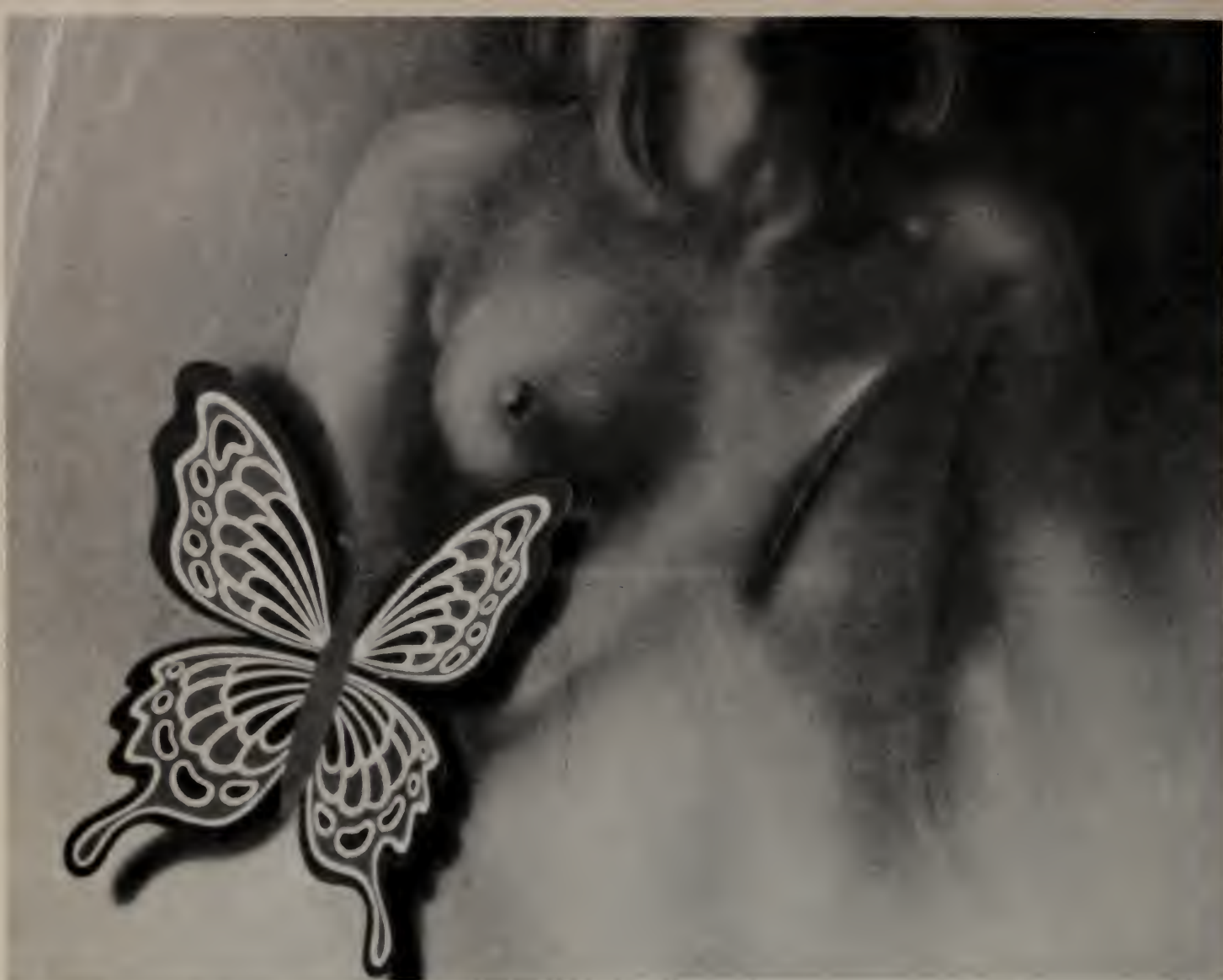
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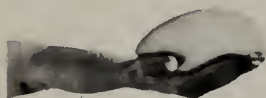




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Annual
Session
1981

The Cover

There is no better way to touch, feel, think about and truly discover our **Environment** than to spend the 111th Annual Session of the Colorado Medical Society at a spot like Keystone. That's not

all there is to the **Environment!** Our cover this month is a symbol of our purpose in this meeting...representing the total earth environment. We are all concerned in this matter: protection of the delicate shell which envelopes the globe. We are also concerned about the spatial environment....possible population of outer space...and it all adds up to many medical questions and judgements. When the writers and editors of *Colorado Medicine* asked our artist, Woody Colahan, how he would capture the meaning of **Environment** in a single picture, he replied very quickly with the design on our magazine cover: the bottle which encloses the earth, and which has become more of a test tube, a waste producer, a threat and hazard to life....take your choice. The Annual Meeting Scientific Session theme is "The Environment, From the Local Community to Outer Space," and our theme is illustrated throughout this magazine....designed as your program guide through the entire 5 day session at **Keystone**.

- 281 111th CMS Annual Session/House of Delegates** meeting schedule and program begins here, but there's much more on the pages to follow.
- 282 Welcome to Keystone!** A taste...and a feel...of the Keystone, Colorado environment....entertainment/diner's guide superb!
- 284- Tennis or Golf, anyone?** This is the location of your registration necessities to get into the flight of your choice.
- 285**
- 287 "Environment,"** an outstanding **Scientific Session**....with credits and nationally-known speakers (Complete program starts here!)
- 290- Annual Session pre-registration and program information:**
- 291** Everything you need
- 297 CMS Annual Session program schedule:** Everything you want to know
- 300- AAMA program and registration** for Medical Assistants meetings and
- 301** CME
- 302 Annual Session Business Meeting Schedule:** Easy to keep track of where you want to be!
- 303 House calendar** for: credentials committee, reference committees, etc.
- 304 Friday Caucus Schedule** with rooms assigned
- 306 Report from the Board of Medical Examiners**
- 308 Brian O'Leary, A Man for All Reasons**....if they are environmentally sound. Brief biography and interesting sidelights about the Keynote Speaker

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president's letter

to letters the editor



This may well be my last President's Letter. I have the feeling that the 1981 Presidential Planning Session (which will have completed course by the

time you receive this) will have been so productive that I need say no more concerning the future of the Colorado Medical Society. I want, instead, on the eve of our 111th Annual Session, to point out the gravity of the meeting of the House of Delegates and the related business activities which will take place at Keystone.

This year is a milestone in the CMS growth: we have embarked on an independent insurance trust which, I believe, will help in the furtherance of private practice medicine in Colorado; CMS is working toward building a permanent headquarters for its members, in which each of you will have an equity; your Board of Directors, during the past year, has encouraged and approved the reorganization of COMPAC, providing funds and effort to its membership development; during this year the CMS has made a concerted effort to aid the medically indigent in Colorado by strongly supporting proposed MI legislation; we have committed ourselves to continued support in the interest of this bill's passage during the 1982 General Assembly; your state legislature will meet again in September to wrestle with (and hopefully decide on) the reapportionment issue, and you'll be hear-

ing from legislative leaders on this matter during our Annual Session.

This year the Colorado Medical Society and the Colorado Foundation for Medical Care Boards of Directors will hold a joint meeting in their on-going effort to improve the productivity of both organizations. We have made substantial gains during this year in mutually developing future courses for the Foundation and the Society.

All of these subjects will come before the physicians attending this meeting, and I believe it vitally important that we have as large an attendance as possible from our general membership. Yes, the delegates and alternate delegates to the House will be there, but they need your voice, your opinion, your interest!

The CMS Scientific & Professional Education Department has brought together an excellent session concerning The Environment, with a wide variety of programs and nationally-known authorities, all with appropriate CME credit.

The Colorado Medical Society Auxiliary has an outstanding program for physician's spouses, and I urge all of you to encourage your wife or husband to attend and participate. In addition, the American Association of Medical Assistants is holding its meeting, jointly, with the CMS Annual Session.

Of course, there are many other events, such as the golf and tennis tournaments, and a full menu of individual and family activities in the Keystone vicinity. I extend my wholehearted invitation to you all to participate, and I hope to see you at Keystone.

As you are no doubt aware, the House of Delegates at the 1981 Annual Meeting in Chicago adopted a direct membership option in the AMA.

We want to reconfirm that the AMA will continue to place primary emphasis on recruiting physicians through the federation and encourage them to join their county, state and specialty society as well as the AMA. Direct membership promotion will only be used to recruit physicians who are not responsive to coordinated marketing efforts with counties and states and to recruit physicians in areas where such efforts cannot be implemented. In any event, direct solicitations will not be sent until after May 1, 1982, and will not be sent in unified states at all.

As part of the procedure for implementing the direct membership option, the AMA will establish an appropriate mechanism for the review of membership candidates by state societies. Direct members from each state will be counted for the purpose of determining the number of delegates to the AMA House of Delegates from each state.

Within the next few months, further communications will be sent to you on this important topic. There will also be three regional meetings—two in July and one in August; at which time this option will be further explained. Personal visits from the staff of the newly-created AMA Division of Membership will continue as in the past. We intend to keep all of you fully informed of our activities and procedures in this area.

Included is a list of the five most asked questions on the subject which should assist you in better understanding the direct membership option.

If you have any additional questions, please contact the Division of Membership at the AMA.

James H. Sammons, M. D.

111th Annual Session

"THE ENVIRONMENT"

Colorado Medical Society and Auxiliary

SEPTEMBER 8,9,10,11 & 12, 1981

KEYSTONE LODGE, KEYSTONE, COLORADO

REGISTRATION FORMS INCLUDED

Admission to all events is by Registration Badge Only

WHO MAY ATTEND

DOCTORS

All physicians including interns and postgraduate residents are welcome. Physicians from states other than Colorado will be charged a registration fee of \$25.00.

OTHERS

Except for persons indicated above, others may register and attend appropriate parts of the Annual Session only when individually and continually accompanied and sponsored by a member of the Society.

DOCTORS' SPOUSES

They are welcome at scientific meetings. See Auxiliary Program on page 290 for special functions of interest to the ladies.

SCIENTIFIC SESSIONS

Presented by Council on Professional Education of the Colorado Medical Society and The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Avenue, Denver, Colorado 80262.

As an organization accredited for continuing medical education, the University of Colorado School of Medicine certifies that this continuing medical education offering meets the criteria for 5 hours in Category 1 of the Physician's Recognition Award of the American Medical Association provided it is used and completed as designed.

This program has been reviewed and is acceptable for five (5) elective hours by the American Academy of Family Physicians.

ALLIED PROFESSIONS

Dentists, Nurses, Pharmacists and other professional men and women allied with medicine are welcome to register and attend the sessions without fee.



KEYSTONE LODGE

Colorado Medicine for August, 1981

Welcome to Keystone

Right now, you're about 9,300 feet above sea level. The air is thinner up here, and it's important that you slow your daily pace a little to allow your body the proper time to familiarize itself with our mountain atmosphere. Also watch out for the sun. Even though we're still almost 93 million miles away, the effects of the rays up here require certain small precautions.

Keystone Environment

Here are a few tips that will help you more fully enjoy your Keystone stay. First, eat a hearty breakfast before rambling off into the mountains. Second, use a good suntan lotion, preferably with a sunscreen. It also helps to carry a moisturizer for your lips, and to wear sunglasses. Lastly, be sure to bring warm clothing if you're planning to be out all day as the weather can change rapidly.

Keystone Activities Center

If you have any questions about what to do at Keystone, call the Activities Center, located in the Plaza next to the Brasserie, 468-2316, ext. 3866. The Activities Center offers complete information and accepts reservations for the varied activities available at Keystone Resort and in Summit County. Open from 8 a.m. to 6 p.m. daily. All activities must be arranged through the Sports Desk and cancellation of activities due to weather is possible.

Picnics

Picnics, mountains and summer—natural go-togethers. The staff at Keystone Resort will prepare a unique picnic lunch for you and your family. A large wicker basket holds samples of Colorado specialties, buffalo salami, fried chicken and more; beer, wine or soft drinks, and a checkered tablecloth. For reservations and costs, call the Activities Center, 468-2316, ext. 3866.

Sailing

Lake Dillon, Five miles west of Keystone, has a 25-mile shoreline surrounded by Rocky Mountain majesty. Keystone's own 25-foot sailboat also may be chartered for daily trips. Beverages are provided. For reservations, call the Activities Center.

Lake Dillon Sailboat Cruise: \$12 per person (children ages 5 through 12, \$8) for 1½ - 2 hour cruise. Departs three times daily from the Dillon Marina. Reservations are required. Hourly charter rates: \$10 per person (minimum five people). Private lessons: \$50 for one hour (includes boat). Small Sabot Sailboats are available for cruising around Keystone Lake. Sailboat rentals, \$4 per half-hour.

Kayaks and Paddleboats

Rentals for use on Keystone Lake are available from the Activities Center. What a pleasant way to enjoy the sunshine. Paddleboats: \$4 per half-hour. Kayaks: \$3 per half-hour. Family rate: \$15 per half-hour.

Fishing

The lakes and rivers of Summit County offer brook, rainbow and German brown trout, as well as Kokanee salmon. Keystone's staff expert knows all the secret fishing spots in the area. Fishing licenses may be purchased at the Sport Stalker in the Argentine Plaza.

Raft Trips

Enough whitewater for excitement, but not too much for the novice, awaits you on guided one-day raft trips. Offering experienced guides and indigenous Colorado lunches, the raft trips depart daily from the Activities Center. Reservations are required. Colorado River trips cost \$40 per person. Arkansas River trips cost \$45 per person. Children 8 through 12, \$27.50. Group rates (10 or more) are \$35 per person. Call 468-2316, ext. 3866.

Bicycling

This is an ideal way to see Keystone Resort and its surroundings, from the Mountain House to the Keystone Stables. Paved bike paths along the Snake River provide a pleasant route through the resort. Rentals are available from the Activities Center at \$3.50 per hour, children (12 and under) \$2 per hour. Family rate is \$12 per hour. Half-day rentals are \$12. Tandems are available at \$5 per hour.

Keystone Environment

Sightseeing Tours

Guided bus tours depart weekly from the Keystone Lodge to the historical sites in Summit County. Visit the abandoned silver mines of the Montezuma Basin-Peru Creek area for great scenery coupled with western folklore and history. Tours through the Climax Molybdenum Mine near Leadville may be arranged. Reservations are required. Call the Activities Center for departure times. Cost is \$12.

Western Barbecue

For a taste of the Old West, Keystone's Wednesday evening ranch-style cookout features the live music of Rocky Starr. The barbecue grounds are located at the southeast end of Keystone Lake near the Snake River. Chicken, ribs or steak from \$12.00 to \$20.95. Cocktails, beer and wine are available from the Straight Shot Saloon. Come early

ANNUAL SESSION
Keystone, Colorado
September 9-12, 1981

The above information graciously supplied by the Keystone resort and Keystone area merchants.

Keystone Environment

and pitch a few horseshoes or play volleyball. When the sun goes down, relax and roast marshmallows around the campfire. For reservations, call the Activities Center.

Horseback Riding

The Keystone Stables are located a half-mile from the resort in the old community of Keystone. Rental horses and a variety of special rides are available. Guides take you on trails along the Snake River Valley and up into the pine forests. Reservations are necessary for all rides; call the Activities Center, or the Stables, 468-2316, ext. 3814. One hour rides \$9 per person. One and one-half hour rides \$12. Two-hour rides are \$14.

Overnight Trail Rides

Relive the west, the way it was, on an overnight horseback trail ride into the back country of the Arapaho National Forest. Western-style dinner and breakfast and rustic lodging offer an experience to remember. Call the Activities Center, 468-2316, ext. 3866, or the Stables, ext. 3814 for prices and full information.

Backpacking

The Arapaho National Forest provides backpackers with some of the most spectacular scenery in the U.S. Well-marked hiking trails in the immediate area all lead to adventure. The Activities Center can supply you with all the information you need to outfit yourself and explore the forest.

Jeep Tours

Spend two hours in the high country, touring Arapaho National Forest, deserted mining camps and meadows full of Colorado wildflowers. Check with the Activities Center for daily tour departure times. Reservations required. Adult, \$20. Children (12 and under), \$18.

Shopping

One of Keystone's truly great indoor activities. With many interesting shops on two plazas, you'll have afternoons of fun on the shopping circuit. From antiques to boutiques, casual to western attire, gifts to goodies and everything in between, shopping at Keystone is a world unto itself.

For Kids Only

Trust your children to the professional care of our experienced staff and enjoy your own time at Keystone Resort. Location: Mountain House Children's Center. Call 468-2316, ext. 3889.

Children's Activity program (ages 5-12), includes hiking, swimming, boating, fishing, arts and crafts, and more. 8 a.m. to 5 p.m. daily. All day, including lunch, \$25. Half day, morning or afternoon, \$15.

Special Activity Program (ages 6-12), includes rafting on the Colorado River, jeep and hiking trips, sailing on Lake Dillon, and sightseeing tours. All day, including lunch, \$30.

Child Care Program, with a minimum age of one year. All day including lunch, \$18. Hourly rate, \$3. Lunch option \$2.

Babysitting. Care for infants or evening babysitting may be arranged by request. Reservations must be made by 1 p.m. on the day service is needed.

Keystone Environment

Teen Center

The Soda Ridge Roadhouse is the center of the 12 to 18 year old group, featuring pinball, foosball, pizza, dancing, electronic video games, TV with Home Box Office Programming, and a jukebox. Located in the Argentine Plaza; open daily from 4 p.m. to 10 p.m. Call 468-2316, ext. 3794.

The above information graciously supplied by the Keystone resort and Keystone area merchants.

Dining Guide — Keystone —

In The Keystone Lodge:

Bighorn Steakhouse

Now that you're in the mountains, you probably notice something happening in your stomach: hunger. Don't worry, just head on down to the Bighorn Steak house. The New Yorks, filet mignons, and the prime rib are as good as any in Colorado, which is the same as saying anywhere in the world. But that's not all. The Bighorn has Rocky Mountain trout, Alaskan King Crab Legs, fresh-baked bread, fresh vegetables and delicious desserts. And the salad bar has to be experienced to be believed. They don't call it the Bighorn for nothing. 5:30 until 10:00 p.m., Sunday through Thursday; 5:30 p.m. to 10:30 p.m., Friday and Saturday. Telephone 468-2316, ext. 3740. No reservations. Cocktails, beer & wine. All major credit cards accepted.

ANNUAL SESSION Keystone, Colorado September 9-12, 1981

Garden Room Restaurant

Elegant dining. Overlooking Keystone Lake, and the rugged peaks of the Continental Divide, the view at the Garden Room is surpassed only by the uncompromising cuisine. Specialties include duck a l'Orange, Steak Diane, Veal Oscar, and a glittering array of tempting desserts, along with a complete wine list. Service is a la carte. In addition, the chef selects a specialty each night to be served as a traditional style dinner. For something special, experience the elaborate Sunday Brunch, served from 10:00 a.m. until 2:00 p.m. Dinner 6:00 p.m. until

For more information:

**Keystone
Box 38
Keystone, Colorado 80435
(303) 468-2316**

Keystone Environment

Golf at Keystone

The Director of Golf is Dave Stickton. Professional: Laurie Hammer. Keystone's 18-hole, championship golf course is located three miles south of the resort in a spectacular mountain valley, the site of the Keystone Ranch. Designed by Robert Trent Jones, Jr., this 7090-yd. course retains the rustic flavor of the area, first settled in 1870. Holes play through the woods, meadows, and valleys and across a nine-acre lake. Old West ambiance may be enjoyed in the spacious, 50 year old Ranch house with its living room, dining room, bar, proshop and locker rooms. Golf carts are required. The golf course is closed on Mondays.

Green fees: 18 holes, \$22; 9 holes \$11. Golf Cart \$8 per person for 18 holes; \$4 per person for 9 holes.

No caddies are available and pull carts or walking is not permitted. Lessons: \$20 per half-hour, including range balls. Club rental, cleaning and storage is available. Starting times are required. Call 468-2316, ext. 3904.

Fourteenth Colorado M.D. Invitational Golf Tournament September 8, 1981

Entry fee: \$15:00 per person - does not include green fee and cart for two (mandatory) which is \$30.00 per person payable at the Pro Shop.

One day of play. Tuesday, September 8. Since many players do not have established handicaps, play will be on the **Calloway System**.

Starting times have been reserved on the course from 9:30 to 10:40 a.m. Play is to be in foursomes arranged by the contestants and tee off times must be requested at the Pro Shop.

Your check, made payable to the Colorado Medical Society, for the golf and tennis tournament registration should reach the CMS Executive Office by August 28.

Annual Colorado Medical Society Tennis Tournament

One day of play Tuesday Morning, September 8. Play will be between 10:00 a.m. and 1:00 p.m. Registration fee: \$7.50 - does not include court fee. A drawing will take place at 10:00 a.m. for those of you who have not pre-arranged for a partner. You must be pre-registered and must be present at the drawing. Play will be between partners of equal level. Registration will be at the John Gardiner Tennis Court.

TWO-LEVEL COMPETITION:

A Level - Consistent players

B Level - Average players

Keystone Environment

Tennis

The John Gardiner Tennis Ranch at Keystone features 14 courts, two of them indoors, a fully-equipped Pro Shop, and an expert staff to help you with anything from tennis clinics to arranging matches. Courts are open from 8:30 a.m. until dark. Court rates for guests are \$7 per hour and \$8 per hour for non-guests. Tennis attire and tennis shoes are required at all times. Call 468-2877 or 468-2316, ext. 3770 for reservations.

Instruction: Group lessons (3-6 people) are \$12 per person per hour. Private lessons \$25 an hour. Semi-private lessons (2 people) are \$30 an hour. Ball machines are available at \$7.50 per half-hour. Hosts (playing with Pro) \$7.50 per half-hour. Racket and shoe rental \$2 per day. Training Aids: Videotape, ball machines and rebound nets are also available.

Special clinics: The Week-long (5 day) Clinic includes 20 hours of group instruction, strategy sessions, pro exhibition, champagne graduation and much more. Cost \$295, or \$60 on a daily basis. The Weekend Clinic includes 8 hours of group instructions, pro exhibition match and more. Cost is \$100 per person or \$35 per session.

**Fourteenth Colorado M.D. Invitational Golf Tournament
September 8, 1981 - Advance Registration**

Name (Print)_____Partner _____

Address_____

ENTRY FEE: \$15:00

Check must be recieved before August 28.

TUESDAY, September 8, 1981

9:30 a.m. Golf Tournament - Keystone Golf Course

10:00 a.m. Tennis Tournament - John Gardiner Tennis Club

7:00 p.m.- Welcome Reception

8:00 p.m. Gallery & Lakeside Suite

**Annual Colorado Medical Society Tennis Tournament
Tuesday Morning, September 8 - Advance Registration**

Name (Print)_____Partner _____

Address_____

Indicate level of competition:

A LEVEL (consistent players)_____

B LEVEL (average players)_____

ENTRY FEE: \$7.50—

Check must be received before August 28.

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Medical Student Component Report

by Mary Ruth Salazar, MS II,
President.

Greetings from the officers and members of the Student Medical Society! Summer finds us gearing up for a terrific year of education and enrichment, community service and participation in organized medicine. Many enthusiastic and fruitful hours of meeting with the officers of other medical student organizations (Minority Student Organization, Women's group, Black Student Organization and American Medical Student Association) have yielded a cornucopia of fresh ideas as well as a commitment to cooperation between these various student organizations.

Our education and enrichment brainstorming is being sculptured to reveal the sponsoring of a medical sign language class to coincide with the International Year of the Handicapped. We plan to offer a Beginning Sign Language class for 8 weeks during the fall, winter and spring quarters, with an eye toward chiseling out an Intermediate Sign Language class in the winter and spring quarter, depending on demand. This course will be opened, first, to the students and then to medical personnel. Also in the making is to invite physicians and other professionals to speak to the issues, such as: rural medical practice; group practice versus solo practice; and dealing with the bereaved.

Community service opportunities which we hope to offer include: blood pressure screening in minority populated areas; participation in the Channel 9 Health Fair; hospice work, and; teaching first-aid and CPR to high school students and adults.

This year we have about one-fourth of our membership involved in councils, committees, AMA delegation and CMS delegation.

After looking to the future, let's look back to give recognition to the academic achievements for which our members were honored at the 1981 Spring Honors Convocation.

We heartily congratulate:

Rachael Wood, recipient of the Charles S. Glascoe Memorial Scholarship for excellence in medicine.

Robert Rifkin, recipient of the Edward G. Stoiber Award as an Outstanding Junior, and receiving membership in the Alpha Omega Alpha Honorary Fraternity.

Steven Lewis, recipient of the Joseph and Regina Glazer Research Prize for Outstanding Research, and received membership in the Alpha Omega Alpha Honorary Fraternity.

Rosemary Wood, recipient of the Alpha Omega Alpha Award for excellence in anatomy.

David Lacey, recipient of the Richard M. Mulligan Award for proficiency in pathology.

Mark Lovell, recipient of the Robert H. Felix Award for his psychiatric thesis.

Paula Dosen, recipient of the George Packard Award for surgery.

William Atherage and *Donald Putzier** were recognized for Outstanding Performance in their Freshman Year.

*Joseph Jiminez,*** recognized for Outstanding Performance in his Sophomore Year.

* CMS Vice President, 1981-82

** CMS President, 1980-81

A special note to physician members of Colorado Medical Society: If any of you would like to contribute your service/expertise in meeting any of our goals, please feel free to contact me at 343-0823.

Here's to a great year!

**JOIN YOUR FELLOW
MEDICAL
PROFESSIONALS
AT KEYSTONE LODGE,
SEPTEMBER 8 -12, FOR
BUSINESS AND
PLEASURE!**

WEDNESDAY, September 9, 1981

8:00 a.m. Registration - Gallery

9:00 a.m.- SCIENTIFIC SESSIONS - "The Environ-
11:00 a.m. ment—From Local Community to Outer Space" - Ten Mile Room

9:00 a.m. "The Air As Environment" - a Panel Discussion

STEVEN J. DURHAM, *Regional Administrator for the Environmental Protection Agency, Region 8*

MICHAEL HENRY, *Chairman of the Colorado Air Pollution Control Commission*

11:00 a.m. KEYNOTE SPEAKER - "Exploring New Worlds and Living in Outer Space" - an illustrated talk.

BRIAN O'LEARY, Ph.D., *Former Appollo Astronaut, Astrophysicist, Futurist, and Author.*

Noon Luncheon - "Food Faddisms, Cultisms, and Quackery" - Garden Room

WILLIAM JARVIS, Ph.D., *Associate Professor, Loma Linda University (Sponsored by Dairy Council)*

12:15 p.m.- Luncheon - Panel Discussion

1:45 p.m. "Physician's Issues in Workmen's Comp." - Gold Camp/Gold Streak Rooms

CHARLES McGRATH, *Director, Division of Labor*

MILO HARRIS, *Attorney, State Workmen's Comp. Fund*

COMMISSIONER RICHARD WISE, *Industrial Commission*

2:00 p.m. SCIENTIFIC SESSIONS - "The Environment from Local Community to Outer Space" - Ten Mile Room

"Radiation in the Environment: The Hidden Dilemma" - A Panel Discussion

LESTER LAVE, Ph.D., *Brookings Institution*

JAMES MARTIN, Ph.D., *Environmental Protection Agency*

WILLIAM HENDEE, Ph.D., *Chairman, Department of Radiology, University of Colorado School of Medicine*

4:30 p.m. "Ask the Expert" Session (Speakers will attend and talk with participants)

7:00 p.m. Specialty President's Dinner

"Chiropractic"

WILLIAM JARVIS, Ph.D., *Associate Professor, Loma Linda University, Pres. Calif. Council Against Health Fraud (Sponsored by Dairy Council)*

Chairman Mildred Doster, M.D., reported that Thomas Washburn, M.D., attended the Conference on Effects of Nuclear War on April 3-4 as the representative of Denver Medical Society and the CMS Council on Public Health. Council members expressed concern that, while medical groups are marshaling some facts against nuclear war, little is known of actual emergency plans. At the suggestion of Roger Mitchell, M.D., members agreed that it would be worthwhile to seek information about Colorado's preparedness to deal with a nuclear holocaust. Council members requested that, as a first step, Dr. Mitchell talk with Frank Traylor, M.D. (Colorado Department of Health) about state planning for nuclear emergencies and inform the Council. Carol Tempest, CMS Lobbyist and Director of the Division of Governmental Affairs, reported on CMS-supported legislation concerning Public Health, including the Distressed Hospitals Bill.

A statement on Medical Evaluation of Handicapped Children proposed by William Frakenburg, M.D., University of Colorado School of Medicine, for support by the Colorado Medical Society, has been approved by the CMS Board of Directors.

Chairman of the Committee on Maternal and Infant Health, John G. McFee, M.D., commented that cuts in support of care for the medically indigent will be most destructive to preventive care, predictably heightening future problems.

Dr. Doster reported for David Greenberg, M.D., Chairman of the Committee on Medical Aspects of Sports, that about 75 physicians have been recruited who are willing to staff athletic running events.

Dr. Mitchell, Chairman of the committee on environment, brought word from the April meeting of the American Thoracic Society that a committee has been appointed to develop a position on air pollution control. UCSM's Department of Preventive Medicine has created a new division, "Occupational and Environmental Lung Disease".

Update on Medically Indigent

by Carol Tempest

The medically indigent problem goes on and on and on. Early attempts to alleviate it began eight years ago as a line item in the Long Appropriations Bill. This was simply a trade-off between the suburban counties and Denver to provide a little relief for Denver General Hospital for medical services rendered non-Denver indigent persons. Recipients of the program are Colorado residents whose income falls within the parameters set forth in the University Hospital Ability-to-Pay scale and who are not eligible for Medicare, Medicaid, CHAMPUS, or medical benefits under third-party coverage. Only four hospitals in the state participate in the program. University Hospital receives its own direct appropriation through the Department of Higher Education for teaching purposes, and this is applied to the clinical program for indigent care and for the operation of the hospital.

Because medical indigency has never been defined by law and because the line item appropriation is woefully inadequate, a series of bills have been introduced in the legislature to bring some sort of relief to the patients and providers involved. The first such bill was written by

a legislative interim committee in 1977 and introduced in the 1978 session. It spoke only to a prenatal-perinatal care program for the medically indigent, but was not passed by the legislature. 1980 saw the introduction of three bills addressing the subject, all of which were killed at an Appropriations Committee level. And again this year Representative Betty Neale introduced a bill establishing a three-year pilot program to study the feasibility of providing group health insurance to medically indigent individuals and also establishing a three-year pilot catastrophic program. Again the bill was killed in the final days of the session at an Appropriations Committee level.

The issue now resides in yet another interim study committee where the answers to the legislature's questions may or may not be answered. "How many dollars are being poured into programs now—is it a bottomless pit?" "Is this a form of socialized medicine?" "What are the cost containment measures in such an approach?" "Where is the accountability?" "Will the cost of my health insurance premium increase?" and so forth. Private foundations are even being asked to fund such studies.

In short, everyone's tired of the subject but admits that a solution is needed. In the meantime hospitals are charging their paying patients more in order to make up for medically indigent losses, and more and more hospitals are refusing or, at least, limiting the number of MI admissions. Expect at least two bills to be introduced in the 1982 legislative session, and expect another long, up-hill battle.

FALL MEETING, SEPTEMBER 8-12, KEYSTONE COLORADO MEDICAL SOCIETY AUXILIARY

AGENDA

Keystone Conference Center

September 9-12, 1981

Phone: 468-2316

Registration: Wednesday, September 9,
1—4:00 p.m., Gallery
Thursday, September 10, 8:00
a.m.—12:00 noon, Gallery

Wednesday, September 9, 1981

12:15 p.m. Two open CMS luncheons, \$7.50
per person, room to be posted.
"Food Faddism, Cultism and
Quackery," Speaker: William Jar-
vis, Ph.D., Assoc. Prof. Loma Lin-
da Univ. Sponsored by Dairy
Council,
or

Panel Discussion "Physician
Issues in Workmen's Compensa-
tion" Charles McGrath, Director,
Div. of Labor; Milo Harris, At-
torney, State Workmen's Com-
pensation Fund.

6-7:30 p.m. Informal Cocktail Reception,
CMS Pres. and Pres. Elect, Argen-
tine Condominium.

Thursday, September 10, 1981

7-8:30 a.m. Prayer Breakfast, Garden Room,
\$4.25 per person.

8:30-9:00 a.m. Coffee and Rolls, Silver Rooms.

9-10:40 a.m. CSMA Board Meeting, Silver
Rooms.

10:40 a.m. Shuttle Bus Service, Keystone
Lodge, Mall Entrance to Ranch
House.

11:00 a.m. Champagne Brunch, Ranch
House, \$14.00 per person. (Price
to include one glass champagne,
tax and gratuity. Cash bar
available.)

12:45 p.m. Shuttle bus service, Ranch House
back to Lodge.

1-3:00 p.m. General Membership Meeting,
Silver Rooms. Speaker: Mrs. Clair
J. Cavanaugh, National AMA-ERF
Chairman.

3:30-4:30 p.m. County Presidents and Presidents-
Elect, "Informal Session," CMSA
President, Pres-Elect. Condo.

5:30-7:00 p.m. CMS Presidents Reception

7:00 p.m. Western Barbeque, Barbeque
Site, \$20.00 per person. (In case
of inclement weather, the Con-
vention Center.)

Friday, September 11, 1981

8:30-
9:30 a.m. COMPAC Breakfast, Garden
Room, \$7.50 per person. "Reap-
portionment, the Key to Your
Future." Speakers: Colorado
Legislative Leaders and Peter
Lauer, Executive Director COM-
PAC.

9-9:30 a.m. Coffee and Rolls, Silver Rooms.

9:30-
10:15 a.m. Treasurer's Workshop, Mrs.
Severence Kelly.

10:30 a.m.-
12:00 noon AMA-ERF Workshop, Mrs. Clair
Cavanaugh, National AMA-ERF
Chairman (Workshops in Silver
Rooms.)

Noon

1:00 p.m. Women's Doubles Round Robin,
John Gardiner Tennis Club. (See
Registration Form Attached.)

Keystone Informal Cocktail Reception

6—7:30 p.m. Wednesday, Sept. 9

Argentine Condominium

All auxiliaries and their spouses are invited to join us for cocktails.

Jerri Fowler
CMSA President

Sharon Ritzman
CMSA President-Elect

CMSA Fall District Meetings:

Sept. 15—Greeley
21—Durango
23—Grand Junction
25—Montrose
28—Metro Denver

Oct. 2—Fort Morgan
6—Pueblo

We hope to see all of you (both officers and members) at the meeting nearest you. Bring any problems or questions and we will be happy to discuss them in addition to our workshops.

AMA Auxiliary Newsletter Contest

The AMA Auxiliary is sponsoring a newsletter contest for state and county newsletters. Categories will include state newsletters, state magazines and county newsletters, plus a category for the most improved publication. They will be judged on writing quality, layout, newsworthiness, and effectiveness in promoting auxiliary programs. They will be judged by journalists in the Chicago area. Awards will be given in each category, plus one award for the most outstanding publication in the country. Please send entries before January 1, 1982 to Jerri Fowler.

Advance Registration

Please send form with check payable to Colorado Medical Society Auxiliary to: Mrs. L. D. Cunningham
6555 Bull Hill Court
Colorado Springs, CO 80919

Please indicate events for which you wish to make a reservation. Deadline for reservations is August 31, 1981. Attendance may be limited for some of the following programs, and reservations will be accepted on a first-come, first-served basis. Please send reservations in as soon as possible.

Name _____ County _____
Please print as you wish it to appear on name badge.

Address _____

Position held in state auxiliary _____ Position held in county auxiliary _____
☐ CMSA Member ☐ Non-Member (\$5.00 Registration Fee)



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- ACCOUNTS PAYABLE
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 - vender analysis
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Advance Reservations

Please send reservation with check payable to:

Colorado Medical Society
Attn: Glenda Chipps
1601 E. 19th Avenue
Denver, CO 80218.

Indicate below those events for which you wish to make a reservation. Deadline for reservations is September 4, 1981.

Name _____

Address _____

Wednesday, September 9, open CMS Luncheons:
"Food Faddism, Cultism and Quackery" or
"Physician Issues in Workmen's Compensation"
\$7.50 per person

Number of reservations _____

Amount \$ _____

Thursday, September 10, Annual Prayer Breakfast
\$4.25 per person

Number of reservations _____

Amount \$ _____

Thursday, September 10, Champagne Brunch
\$14.00 per person

Number of reservations _____

Amount \$ _____

Thursday, September 10, Western Barbeque
\$20.00 per person

Number of reservations _____

Amount \$ _____

Friday, September 11, COMPAC Breakfast
\$7.50 per person

Number of reservations _____

Amount \$ _____

Total Amount Enclosed \$ _____

Keystone Environment

The Navigator

Seafood dining in a nautical atmosphere. With all their great specialties, you'll have some difficulty deciding what to order. The scampi is mouth-watering. The crab legs sweet and tender. Seafood specials fresh daily. Of course, there's prime rib, filet mignon and turf and surf. All dinners include salad bar, clam chowder and bread. Open 7 days a week for dinner. Reservations not accepted. Telephone 468-5600 or 468-2316, ext. 3860. Cocktails, beer & complete wine list. Lounge. All major credit cards.

Bentley's

Take a sophisticated cocktail lounge from any of the world's capitals, transport it to the heart of the Rockies, and you have Bentley's, a different mood at Keystone, serving an array of moderately priced lunches, casual dinner entrees and terrific snacks daily. Sit on the deck and

watch the sailors and kayakers, or enjoy some of the best entertainment Wednesday through Saturday nights. 11:00 a.m. to 11:00 p.m. 7 days a week. Happy hour Monday — Friday 4:30 to 6:00 p.m. and Wednesday 9:00 p.m. to midnight. Telephone 468-2316, ext. 3862. Reservations not required. Cocktails, beer & wine. All major credit cards.

ANNUAL SESSION Keystone, Colorado September 9-12, 1981

Silver Seed Emporium

Homemade specialties for any occasion—even catering. Homemade soups and chili, quiches, vegetarian things—even box lunches to go. Stock your condo refrigerator with those items you might have forgotten. Service is quick, food delicious and prices moderate. Dining daily 10:00 a.m. - 7:00 p.m. Reservations not accepted. Telephone 468-2774. No credit cards.

Esteban's

Traditional Mexican and New Mexican dinners served overlooking the Snake River. Homemade specialties include chile rellenos, tamales, enchiladas Santa Fe, chimichangas, seafood enchiladas, avocado salads, American dishes, children's plates, and more. In the greenhouse lounge or on the patio, enjoy sangria, fruit margaritas, sangrita or fine imported tequilas. Luncheon tostado/taco buffets, noon to 2 p.m. Cocktails, noon to midnight. Appetizers, 4 p.m. to 10 p.m. Dinner, 5:30 p.m. to 9:30 p.m. Happy hour daily 4 p.m. to 6 p.m. Telephone 468-0020, or 468-2316, ext 3959. No reservations. Located in the Argentine Plaza. Just outside Keystone.

The above information graciously supplied by the Keystone resort and Keystone area merchants.

Keystone Environment

Office Space For Lease

BUILDING/PROJECT NAME Mississippi Professional Center (Dental, Medical)

Address/City 1040 S. Uvalda Street

Zip 80012

County Arapahoe

Building Rentable — 5,000

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SPACE AVAILABLE 3,000 (will divide)

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Contact: Jay R. Levy

Business: 922-6343

Residence: 757-0527

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(303) 233-6561

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Lakewood, Colorado 80225

AAMA Dedicated to Medical Assistants

The American Association of Medical Assistants, Inc. (AAMA) is a professional organization for medical assistants, secretaries, nurses, technicians, bookkeepers and receptionists who work in a physician's office or another medical facility. It is a national, non-profit organization dedicated to the professional advancement of medical assistants. Its educational services enable members to increase their effectiveness to the physicians and patients they serve. The following is a summary of information about, and services offered by, the AAMA.

Membership—Medical assistants are individuals who work in doctor's offices, hospitals and other facilities, performing both administrative and clinical duties. In Colorado there are five statewide chapters:

Capitol Chapter; affiliate: Denver Medical Society.

Clear Creek Valley Chapter; affil: CCVMS.

El Paso County Chapter; affil: El Paso Co. Med. Soc.

Fremont County Chapter; affil: Fremont Co. Med. Soc.

La Plata County Chapter; affil: La Plata Co. Med. Soc.

You will also find at-large members throughout the state. For membership information or applications, contact Candia Beetha at 1028 E. Boulder, Colorado Springs, 80909, or inquire at the CMS component medical society in your area.

The prime purpose of AAMA is the education of medical assistants. In addition, the association cooperates in sponsoring workshops for medical assisting educators. Many materials, such as an Educational Program Planning Packer, an audio-visual aids list and certification review aids, are available from the Executive Office to help state societies and local chapters plan effective programs at seminars and meetings. Other con-

tinuing education sources are:

1. Guided study programs consisting of cassettes and workbooks. These programs enable assistants to learn at their own pace on their own time.

2. Self assessment programs are offered which consist of 100 questions designed to test individual knowledge. The questions are scored by the participant and a rationale of the answers is provided for immediate feedback on performance.

3. The official bi-monthly journal, The Professional Medical Assistant, is devoted to original articles written for medical assistant by their peers or other professionals in related fields. It is an automatic benefit of membership.

4. The annual convention each fall offers a variety of experts in medical and related fields. These speakers address participants during educational programs and workshops. CEU credit is available for selected workshops and a special program for medical assistant educators is presented each year at this meeting.

5. Seminars and workshops are sponsored throughout the year by local and state medical assisting groups or by regional collaboration. Here again, selected workshops are approved for CEU credit.

The AAMA encourages advancement of medical assistants by offering a Certification Examination designed to evaluate professional competency. Those who successfully complete the examination are entitled to use the CMA designation (Certified Medical Assistant) after their names.

Candidates may also earn specialty certifications in administrative (CMA-A), clinical (CMA-C), and pediatric (CMA-Ped) categories.

The AAMA Curriculum Review Board is recognized by the U.S. Commissioner of Education as an official accrediting agency for medical assisting programs. There are 117 accredited programs across the United States, both in public and private sectors of education.

The Dorothy and Henry Bodner Loan Fund for Certification and Education provides financial assistance in those fields, with no interest rate.

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American Association of Medical Assistants, Inc.

Colorado Society
Continuing Education Seminar

Medical Ethics and Law Human Relations and Communication

Saturday, September 12, 1981
8:00 a.m.-4:00 p.m.

Keystone Lodge Keystone, Colorado

| | |
|----------------|----------------------------------------|
| 8-8:30 a.m. | Registration |
| 8:30- | Medical Ethics and Law-Patrick |
| 10:00 a.m. | Madden, MD |
| 10-10:30 a.m. | Coffee Break |
| 10:30- | Medical Ethics and Law-Patrick |
| 11:45 a.m. | Madden, MD |
| 12-1:15 a.m. | Luncheon-Barbecue Site |
| 1:30-2:30 p.m. | Human Relations and Com- munication |
| 2:30-3:00 p.m. | Coffee Break |
| 3-4:00 p.m. | Human Relations and Com- munication |

Continuing education unit credit will be applied for. Hotel reservations should be made directly with Keystone Lodge (303-468-2316 or Denver 534-7712). One person per room \$57/day. Two persons per room \$60/day. Each additional person per room \$8/day. Make hotel reservations as soon as possible.

Advance Registration

Please send registration form to:

Phyllis L. Shockney, CMA-AC
1409 North Custer
Colorado springs, CO 80903
H: 632-2001
O: 632-7711

- ☐ Member
☐ Non-Member

Seminar registration (luncheon included): \$35.00 for members, \$45.00 for non-members. Registration deadline is Sept. 4, 1981. Please make checks payable to AAMA Colorado Society Educational Fund. This seminar is being held in conjunction with the CMS 1981 Annual Session.

Name _____

Address _____

_____ Zip _____

Phone: Home _____ Office _____ Social Security No. _____

Business Meetings

CMS ANNUAL SESSION, KEYSTONE SEPTEMBER 8 - 12

Wednesday, September 9

9:30-11:30 a.m. Medical Executives Group (MEG)

10:30-11:30 a.m. CMS Finance Committee

12:00-3:00 p.m. CMS Board of Directors

3:00-4:30 p.m. CMS/CFMC Joint Board of Directors Meeting

4:30-6:30 p.m. CFMC Board of Directors

7:00 p.m. Specialty President's Dinner Meeting

Thursday, September 10

10:30-Noon American College of Emergency Room Physicians, Colorado Chapter Board Meeting

11:00-12:30 p.m.

CMS Grievance Committee with Component Society Grievance Committee Chairmen

Friday, September 11

9:00-Noon Judicial Council—Colorado Ophthalmology Society Legislative Keymen/Executive Committee

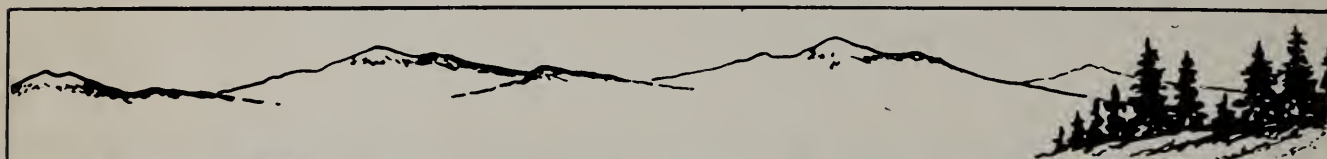
Saturday, September 12

8:00 a.m. CMS Board of Directors Reorganizational Meeting

8:00 a.m.-4:00 p.m. Colorado Society of American Association of Medical Assistants

Sunday, September 13

8:00-Noon Colorado Society of American Association of Medical Assistants



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Roger J. Newton, CPBC

WEDNESDAY, September 9, 1981

- 4:30 p.m. "Ask the Expert" Session (Speakers will attend and talk with participants)
- 7:00 p.m. Specialty President's Dinner
"Chiropractic"
WILLIAM JARVIS, Ph.D., *Associate Professor, Loma Linda University, Pres. Calif. Council Against Health Fraud* (Sponsored by Dairy Council)

THURSDAY, September 10, 1981

- 7:00 a.m. Annual Prayer Breakfast - Gold Camp/Gold Streak Room
- Dr. DAVID BECKMAN
Rockmont College
- 7:30 a.m. Registration - Gallery
- 7:30 a.m. Credentials Committee - Conference Center
- 8:30 a.m.-
10:30 a.m. House of Delegates and General Membership Meeting (Vote on Amendment of Articles of Incorporation of Colorado Medical Society) - Conference Center
- 10:30 a.m.-
Noon CFMC Annual Business Meeting - Conference Center
- Noon Reference Committee Chairmen Luncheon - Garden Room
- Noon Past Presidents' Luncheon - Brasserie Salon
- 1:00 p.m. Reference committee Hearings
Board of Directors - Divide Room
Constitution, Bylaws and Credentials - Sundrift
Foundation Affairs - Ten Mile Room
Interprofessional Relations - Sunburst
Legislation - Quicksilver
Medical Service - Sundrift
Professional Education - Starslide
Public Health - Gold Streak
Socio-Economics - Gold Camp
- 5:30 p.m.-
7:00 p.m. CMS Presidents' and Dean's Reception
(Robert L. Perkins Media Awards presentation) Gallery & Lakeside Suite
- 6:00 p.m. Reference Committee Chairmen Meeting - Windwood Room
- 7:00 p.m. President's Dinner - (Western Barbecue)
Ten Mile/Arapahoe/Divide

FRIDAY, September 11, 1981

8:30 a.m. Colorado Political Action Committee (COMPAC) Breakfast
-Garden Room

“Reapportionment - the Key to Your Future”

PETER LAUER, *Executive Director AMPAC*
SENATOR FRED ANDERSON
REPRESENTATIVE FREDERICO PENA

8:30 a.m. Registration - Gallery

9:30 a.m. Professional Liability Trust - Divide Room

10:00 a.m. Component Society/District Caucuses

10:00 a.m. Denver Medical Society - Ten Mile Room

10:00 a.m. District I - Starslide

10:00 a.m. Boulder County Medical Society - Brasserie Salon

10:00 a.m. Pueblo County Medical Society/District IV -Quicksilver

11:30 a.m. Clear Creek Valley Medical Society - Sunburst Room

11:30 a.m. Arapahoe Medical Society - Sundrift Room

11:30 a.m. El Paso County Medical Society - Brasserie Salon

12:30 p.m. Credentials Committee - Conference Center

1:00 p.m. House of Delegates - Conference Center
Colo. Malpractice in the 80's—CMS Liability Trust

COMPAC Hospitality Suite

5 p.m. — 7 p.m. Wednesday, Sept. 9

11:30 a.m. — 12:30 p.m. Thursday, Sept. 10

5 p.m. — 7 p.m. Thursday, Sept. 10

11:30 a.m. — 12:30 p.m. Friday, Sept. 11

Visit the COMPAC Hospitality Suite for cheese and
cocktails. The suite number will be posted at the
registration desk.

No charge.

COMPAC Breakfast

8:30 a.m. Friday, Sept. 11

“Reapportionment - The Key to Your Future.”

Speakers: Colorado Legislative Leaders;
Peter Lauer, Executive Director,
AMPAC

\$7.50 per person

Annual Prayer Breakfast

7:00 a.m. Thursday, Sept. 10

Speaker: Dr. David Beckman, Rockmont Col-
lege

\$4.25 per person

Luncheon

12:15 p.m. Wednesday, Sept. 9

“Food Faddism, Cultism and Quackery”

Speaker: William Jarvis, Ph.D., Associate Pro-
fessor, Loma Linda University (spon-
sored by Dairy Council of Colorado)

\$7.50 per person

President's Dinner

7:00 p.m. Thursday, Sept. 10

Western Barbecue

Wear your Western Attire.

\$20.00 per person

Colleagues Offer Help To Impaired Physicians

Do you know of a colleague having a problem with drugs or alcohol, or with some other impairment?

Do you have a potential problem yourself?

If your answer to either of these questions is in the affirmative, contact the Physician Health and Rehabilitation Committee of the Colorado Medical Society for assistance.

At the recommendation of the American Medical Association, a few years ago the CMS House of Delegates and the Board of Trustees approved creation of a program designed to help physicians with impairments to confront their problems, to find effective treatment and to help with re-entry into practice while maintaining followup. The approach of the Physician Health and Rehabilitation Committee is as advocator, not disciplinarian. It is hoped that impaired physicians may be helped to realize their full active potential.

The Committee stresses that its role is to help physicians before they become a danger to self or to pa-

tients. If you wish to volunteer to work with the Committee as a possible advocate contact the committee in care of the CMS office, 1601 East 19th Ave., Denver, Colorado 80218.

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- Presenting Yourself
- Nutrition in Your Life

DATES FOR MANAGEMENT ENRICHMENT SEMINARS

SNOWMASS VILLAGE, CO (Wildwood Inn) *Dec. 21-23, 1981

VAIL, CO (Marriott's Mark Resort) Feb. 20-27, 1982

SNOWMASS VILLAGE, CO (Wildwood Inn) March 20-27, 1982

*Room reservations for the week of December 19-26. This is a 3-day seminar only because of the holidays.

Seminars comply with IRS rules to make trip expenses deductible for Doctor and Spouse (and/or assistants).

Fee for Doctor \$225.00 before Sept. 10, 1981, \$275.00 after Sept. 10, 1981

Fee for Spouse and/or business associates \$125.00

To Register
Call or Write:

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Steamboat Village, CO 80477
(303) 879-0911
(800) 525-3402

Library Gleanings

The nation's physicians spent more time with their patients in 1980. Physicians had an average of 112 patient visits per week, compared with 122.7 visits in 1979 and 130.6 in 1978, but the physician's work week continued about the same—44.5 hours of direct patient care in 1980, compared to 44.9 hours in 1979 and 45.4 hours in 1978. These figures are from the new 10th edition of *Profile of Medical Practice 1981*, published by the AMA. The book, which contains statistical information on work patterns, fees and expenses as well as essays on medical economics subjects, is available for \$10 (plus \$1.50 for handling) from AMA Order Dept., OP-325, P.O. Box 821, Monroe, WI 53566

Investigation of Complaints and Discipline by Board of Medical Examiners

The CMS Board of Directors at its May 29 meeting received an Activity Report on the Colorado Board of Medical Examiners, which focused on the Board's activity in investigating complaints and the disciplinary actions taken by the Board in the last five years. The following quotes are from that Report.

"In 1976 the Medical Practice Act was significantly modified by the Colorado Legislature to change the method of handling and investigating complaints and to require mandatory reporting by insurance companies for malpractice settlement or judgement, hospitals that had suspended or revoked the privileges of a physician, and disciplinary action taken by a professional review committee.

"The complaints are investigated by an Inquiry Panel. The Inquiry Panel after its investigation, decides to 1) dismiss the complaint because the complaint is without merit and no further action need be taken or there is no reasonable cause to warrant further action; 2) issue a letter of admonition to the physician for an ethical violation or an instance of misconduct which does not warrant formal action by the Board but which should not be dismissed as being without merit; 3) refer the physician to the Attorney General's office because the investigation discloses facts which warrant further proceedings by formal complaint.

"After the physician has been referred to the Attorney General's office, the Board and physician may enter into a stipulation in which the physician admits to violating the unprofessional conduct section of the Medical Practice Act and a mutually acceptable disciplinary action is taken. Stipulations have worked very well for physicians with an alcohol or drug abuse problem.

"If a formal hearing is held, the Hearings Panel hears the evidence presented by the Assistant Attorney General for the Board and the physician's evidence and determines if the charges were unfounded and unproven or proven. If proven, the Hearings Panel determines the disciplinary action (revocation, suspension, probation, etc.) against the physician.

"During the period 1976-1981, the Board has taken formal disciplinary action against eighty-five (85) physicians. Out of these eighty-five (85) cases, there have been five revocations.

"In the past six months, the Department of Regulatory Agencies has allowed the Attorney General's Office to spend more time on the Board of Medical Examiners' cases. Of the thirty-seven (37) cases in the Attorney General's Office, formal charges have been recently filed in fourteen (14) cases. Without an additional appropriation from the legislature for legal services, the backlog will not be substantially reduced and consequently the board is severely limited in its responsibility of protecting the public's health, safety and welfare."

Grievance

Editor's note: the "Grievance of the Month" column appears each month as an aid to your private practice. Names, of course, are fictitious, but the circumstances are those reported in grievances handled by your CMS Grievance Committee.

Complaint: Miss T. writes the Grievance Committee complaining that she was sexually molested by Dr. Y. during an after hours emergency visit to his office.

Investigation: Dr. Y. does not respond to several attempts by the Committee to contact him.

Disposition: The allegations against Dr. Y. are very serious and could also violate the Colorado Medical Practice Act. The case is, therefore, referred to the State Board of Medical Examiners. The Committee also files charges of contempt by Dr. Y. with the Colorado Medical Society Judicial Council.

| | Hearings | Stipulations | Letters of Admonition |
|-------------------|----------|--------------|-----------------------|
| 1976 | 0 | 2 | 0 |
| 1977 | 4 | 3 | 2 |
| 1978 | 3 | 11 | 9 |
| 1979 | 1 | 7 | 9 |
| 1980 | 0 | 13 | 9 |
| 1981 (to 5/15/81) | 0 | 7 | 5 |
| Total | 8 | 43 | 34 |

A breakdown of unprofessional conduct is the following:

| | Hearings | Stipulations | Letters of Admonition |
|--------------------------------|----------|--------------|-----------------------|
| Personal Drug or Alcohol Abuse | 1 | 23 | 0 |
| Psychological Impairment | 2 | 10 | 0 |
| Sexual Abuse | 2 | 0 | 0 |
| Substandard Care (Malpractice) | 3 | 9 | 33 |
| Medicare/Medicaid Fraud | 0 | 1 | 1 |
| Total | 8 | 43 | 34 |

(All of the Physicians, except one, that have been under a stipulation for drug abuse have told the board that it has helped them solve their abuse problem and has allowed them to return to the active practice of medicine or osteopathy.)

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Chest Physicians
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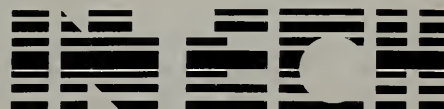
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 - Doctor/producer reports
- **Monthly Reports**
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"EXPLORING NEW WORLDS AND LIVING IN OUTER SPACE"



Brian O'Leary

Brian O'Leary, scientist, author and former astronaut will keynote the Scientific Sessions during the CMS annual Meeting at Keystone Colorado

At 11:00 a.m. Wednesday, September 9, Dr. O'Leary will present an illustrated talk on "Exploring New Worlds and Living in Outer Space."

An experienced speaker and writer on science policy and space exploration, Dr. O'Leary has lectured to diverse audiences and has written numerous popular articles for *The New York Times*, *Science*, *Omni*, *Quest*, and other publications. As a special consultant to the U.S. House Subcommittee for Energy and the Environment, he has written several speeches, statements, and reports on energy issues, was a space and energy policy advisor to presidential can-

didates, and has testified before U.S. Senate committees on priorities in space exploration. He is a contributing editor and special advisor on the space program for *Omni* magazine. A TV and radio personality, he has appeared on the *Today* show and hundreds of other programs. He has taught on the faculties of Cornell, Caltech, the University of California at Berkeley, the University of Massachusetts, Princeton University, and the University of Pennsylvania. His popular book, "The Making of an Ex-Astronaut" was awarded best young adult book of 1970 by the American Library Association and has subsequently been published in four European countries.

In his talk "Exploring New Worlds and Living in Outer Space", Dr. O'Leary lays out the historical role of post-Apollo space explora-

tion by arguing that humanity has the opportunity to open up high orbits in space as energy and material resources for Earth. Profusely illustrated with slides, his talk goes into how it will be possible, within the next ten to fifteen years, to establish space communities and high orbital manufacturing facilities which would make use of materials mined from the Moon and asteroids—a concept first propounded by Dr. O'Leary's Princeton colleague, Dr. Gerard O'Neill. Surprisingly, such an opportunity would require technologies well within our grasp and would cost less than the Apollo program. This is not implausible science fiction. A key feature of this concept is that it is technically possible to draw on resources almost entirely independent of Earth to manufacture space solar power stations which could supply the Earth with virtually unlimited energy by the early twenty-first century. Food and metal resources could also become less expensive than from the Earth, and perhaps just in time to avoid massive world starvation. His book on this subject "The Fertile Stars" was published in May, 1981.

Dr. O'Leary covered the launch of the *Columbia* for the *Today* show and other nationally broadcast programs and says that the success of its mission now proves that the very things about which he talks in his lectures are within our grasp.

Be certain to make the necessary reservations to hear this colorful entertaining and informative keynote address—"Exploring New Worlds and Living in Outer Space," on Wednesday, September 9th at 11:00 a.m.

I WANT YOUR BONES!

The Hall of Life, a non-profit health education center in Denver, needs 2 human skeletons (real or plastic) in any condition. Contact Leo Nolan, M.D., at (303) 237-0486. Gift will be tax deductible.

TFN

PROFESSIONAL OPPORTUNITIES

WESTERN NEBRASKA isn't far from all Colorado has to offer. It also has its advantages, including a population eager to improve medical service and to give respect and a rewarding practice to those who deliver that care. We need especially these Specialists: ORL, Orthopedics, Neurosurgery, Allergy and Dermatology. Other inquiries are welcome. J.C.A.H. Fully Accredited. 124-bed hospital with medical office building adjacent. Write or call for additional information. Paul A. Balerud, Administrator, Great Plains Medical Center, P.O. Box 1167, North Platte, Nebraska 69101. Call (308) 534-9310 or Dr. Mark B. Sorenson, Chief-of-Staff, (308)534-6344. 381-2-3B

WANTED—Family General Practitioner—OB/GYN to serve the progressive growing town of Cutbank, Montana. Liberal first year guarantee and benefits. The community is 40 miles from Glacier Park and offers a variety of outdoor recreation. CONTACT: Al Feldcamp, Executive Director Memorial Hospital, 802 2nd street S.E., Cutbank, Montana 59427. CALL:(406)873-2251. 381-1-6B

GENERAL SURGEON interested in Family Practice needed for established surgical practice with busy family practitioners. Progressive community, good schools, excellent family living opportunities. Newly remodeled hospital next door to medical clinic. Scott City Clinic P.A., 202 College Street, Scott City, Kansas.CALL:(316)872-2187. 581-22-3B

GENERAL SURGEON and INTERNIST wanted in rural community in Front Range area. 34-bed acute care hospital and its medical staff will assist in practice development and can offer part time employment at attractive stipends in hospital and externally based programs. CALL: Robert Black, Adm., St. Joseph Hospital, Florence, Colorado 81226. 681-8-3b

DENVER MD's IN CRITICAL CARE: Consultation services for air ambulance patient transfers. Interested? CALL: Intensive Air Care for information, Monday thru Friday, 8 AM to 5 PM, at 321-2923. 881-4-1b

EMERGENCY MEDICINE—WEST CENTRAL NEBRASKA: Directorship and Clinical positions available in moderate volume ED. Excellent guaranteed income, plus additional stipend for Director's duties. Professional liability insurance provided; flexible scheduling with no on-call responsibilities. For details forward credentials in complete confidence to William Salmo, Chase Stone Center, Holly Sugar Building, Suite 1070, Colorado Springs, CO. 80903; or call toll-free 1-800-525-3681 (outside Colorado) 1-535-8347 (toll-free from Denver) or 1-471-4981 (call collect from other areas in Colorado). 381-2-3B

DIRECTOR OF MEDICAL EDUCATION: needed at Penrose Hospitals, Colorado Springs. Physician wanted to direct a comprehensive and accredited program of continuing medical education. Prior CME experience not necessary to apply. Three years clinical experience required. Contact P.J. O'Rourke, M.D. Chairman, Search Committee for DME, Penrose Hospitals, P.O. Box 7021, 2215 N. Cascade Ave., Colorado Springs, Co. 80907. (303)630-5000. 781-29-3b

ADDITIONAL PHYSICIANS NEEDED: for expanding secondary medical center. Sterling Colorado needs additional physicians in anesthesiology, internal medicine, orthopedic surgery, OB/GYN, ENT, family practice, pediatrician and psychiatry. CONTACT: William W. Ezell, M.D. 1405 S. 8th Ave., Sterling, CO. 80751. CALL (303)522-2264. 481-21-3B

FAMILY PHYSICIANS WANTED to join established practice in Windsor, Colorado. 50 miles north of Denver between Greeley and Fort Collins. For further information call Dr. E. D. Kadlub at 1-303-686-7414. 181-2-1B

KANSAS EMERGENCY MEDICINE: Clinical positions available throughout Kansas. Situations range from moderate to high patient volume.Excellent compensation, plus paid professional liability insurance. Flexible scheduling without on-call involvement. For details, send credentials in confidence to William Salmo, Chase Stone Center, Holly Sugar Building, Suite 1070, Colorado Springs, CO. 80903; or call toll-free 1-800-525-3681 (outside Colorado) 1-535-8347 (toll-free from Denver) or 1-471-4981 (call collect from other areas in Colorado). 381-26-3B

FAMILY PRACTITIONER: Colorado town of 2000 needs two F.P.'s, board certified or eligible, to assume active busy practice 90mi. East of Denver. Supportive and enlightened community had solo G.P. for 17 years; since has expanded to need 2 M.D.'s. With retirement of senior partner, practice is now available to physicians interested in comprehensive rural medicine. Well staffed and fully equipped clinic; modern 21-bed county hospital, well developed referral and C.M.E. network. Prosperous farming and ranching community qualified as B.C.H.S. physician shortage area. Has been preceptor site for U. of Colorado School of Medicine. Active community education involvement, pre-natal classes, EMT training. Heavy on Obstetrics and trauma. Excellent financial situation in extremely stimulating setting; great potential for growth. Contact: Louis Kinkle, Plains Medical Center, Limon, Colorado 80828. CALL: (303) 775-2367. 581-11-3B

CALIFORNIA—Director positions available emergency medicine physicians needed for rural California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA. 94610, (415)832-6400. 381-1-TFN

GROW WITH US IN SUNNY ARIZONA—The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Attractive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living appeal to you, send your CV to: Professional Relations, INA Healthplan, Inc., 6115 North 7th Street, Phoenix, AZ. 85014. 181-1TFN

TWO YOUNG BOARD CERTIFIED Family Practitioners need to replace associate going into teaching position. Desire residency trained Family Physician, near 60-bed hospital undergoing expansion. CONTACT: Donald Potter, M.D., P.O. Box 149, Canon City, CO. 81212 or CALL: (303)275-8646. 581-27-3B

SITUATIONS WANTED

MEDICAL TYPING DESIRED: Expert typist with background in hospital medical records transcription and doctor's office medical typing desires typing to do at home. Have own IBM Selectric II. Prefer work from Brighton / North suburban area of Denver. CALL: (303) 659-9069. 581-1-3b

PHYSICIAN ASSISTANT: 1981 Grad. of AMA approved program seeks employment in intermountain area. ACLS Certified. Flexible, will relocate. Contact: Marcee Morris, 2341 S. Josephine, Denver, Co., 80210 (303) 722-6990. 781-16-1b

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PHYSICIAN'S ASSISTANT—Experienced, certified PA desires long term stable employment by small town family practitioner. Excellent references. Werner Studer, P.A., Box 264 Yellowstone Park, Wyoming 82190. 481-1-3B

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PROPERTIES

FOR SALE: Aurora Medical Clinic, 5 examination rooms, 3 private offices, x-ray room, lab, reception area for doctors, dentist area, plenty of parking. Practice and buildings for sale. Owners retiring and will finance responsible buyers. CALL: Jerry Bartscherer for details. OFFICE: (303) 758-7611, RES: 789-9569. THE DEVONSHIRE COMPANY. 481-1-3b

MEDICAL SPACE FOR LEASE: Finished suites from 650 to 1440 square feet available in August. Professional building located in Denver suburb within one mile of two major hospitals. Reasonable rates and adjacent free parking. CONTACT: Pat at (303)399-6580. 581-13b

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MISCELLANEOUS

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OCTOBER 12-13, 1981: South Dakota Perinatal Association Sixth Annual Perinatal Conference: Holiday Inn, Spearfish, S.D. 9.6 hours credit applied for. Guest speakers include: Preston Dilts, M.D., John Grossman, M.D., George McCracken, M.D., Lu-Ann Papile, M.D. CONTACT: Margo Varcoe, R.N., S.D.P.A., 1100 S. Euclid, Sioux Falls, SD. 57105. CALL: (605) 339-6578. 781-23-1b

CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

September

3-5 **29th Annual James T. Waring Chest Conference.** Longs Peak Inn, Estes Park, Colorado. Contact: Tony Marostica, American Lung Association, 1600 Race Street, Denver 80206. (303) 388-4327. (10 hours of AMA Category 1 credit).

4-6 **Pediatric Neurology Mini-Course.** Keystone Resort, Colorado. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Avenue, Denver 80218. (303) 861-6949. (AMA Category 1 Credit available).

10 **Controversies in the Practice of Pediatrics: ongoing.** Sponsored by The Children's Hospital, Denver; Department of Pediatrics, University of Colorado, Health Sciences Center. Held at various locations. AMA Category 1=6 hours per session. Contact: Health Education Department, The Children's Hospital, 1056 East 19th Avenue, Denver 80218; Tele: (303) 861-6949. Fee: \$45.00.

17 **Neonate Conference:** sponsored by American Lung Association of Colorado. Conference to be in Alamosa, Colorado, conducted by The Children's Hospital in Denver. Contact: American Lung Association, south region, 119 West 6th, Pueblo, Colorado 81003; Tele: (303) 543-LUNG.

25-26 **9th Annual Phelps Pulmonary Conference,** at the Don K Ranch, near Pueblo. Contact: American Lung Association, South Region, 119 West 6th, Pueblo, Colorado 81003; Tele: (303) 543-LUNG.

25-26 **The Medical Consequences of Nuclear Weapons and Nuclear War:** sponsored by The Department of Medicine, University of New Mexico and Physicians for Social Responsibility. To be held at the Regent Hotel in Albuquerque. (9 hours). Contact: Linda Taylor, New Mexico Physicians for Social Responsibility, P.O. Box 4096, Albuquerque, New Mexico 87106; Tele: (505) 262-1862.

25-26 **10th Annual Montrose Fall Clinics.** Contact: Kathy Holman, Montrose Memorial Hospital, 800 South Third St., Montrose, Colorado 81401; Tele: (303) 249-2211. 10 CME hours.

27-30 **Sports Medicine Now:** sponsored by The Department of Family Practice & the Office of Continuing Education of the School of Medicine at the University of California, Davis, in cooperation with University Extension. Site: Stanford Sierra Lodge, Fallen Leaf Lake (South Lake Tahoe), California. Tuition: \$200 M.D.s; Credit: 22½ hours of Category 1 credit. Contact: Ardi Neiswonger, Publications Representative, Office of Continuing Medical Education, School of Medicine, University of California at Davis, Davis, CA 95616; Tele: (916) 752-0328.

October

5 **What You Should Know About Anticoagulants.** Burlington, Colorado. Contact: Martin Rubino-witz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver 80202. (2 hours of AMA Category 1 Credit; 2 prescribed hours of AAFP Credit).

5-9 **Clinical Management and Control of Tuberculosis,** at Denver; sponsored by National Jewish Hospital & Research Center/National Asthma Center, Denver. Course Director: Thomas Moulding, M.D.; 40 hours of AMA Category 1 credit, AAFP credit pending; registration fee \$300, \$150 for physicians in training. Contact: Shirley Maris, NJH/NAC, 3800 East Colfax Avenue, Denver 80206; Tele: (303) 388-4461.

10-11 **The Charley J. Smyth Symposium on Arthritic and Rheumatoid Conditions of the Upper Extremity.** The Fairmont Hotel. Contact: John A. Boxwick, Jr., M.D., 4200 East 9th Avenue, Box C-309, Denver. (303) 394-8718. (14 hours of AMA Category 1 Credit).

12-13 **South Dakota Perinatal Association Sixth Annual Perinatal Conference.** Holiday Inn, Spearfish, South Dakota. 9.6 hours credit applied for. Guest speakers include: Preston Dilts, M.D.; John Grossman, M.D.; George McCracken, M.D.; Lu-Ann Papile, M.D. Contact: Margo Varcoe, R.N., S.D.P.A., 1100 S. Euclid, Sioux Falls, South Dakota 57105; Tele: (605) 339-6578.

17 **Practical Applications of Allergy for Primary Care Physicians at NIH,** Bethesda. 6 hours of AMA Category 1 credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital, 3800 E. Colfax Avenue, Denver 80206; Tele: (303) 388-4461.

November, 1981

1-5 **88th Annual Convention of the Association of Military Surgeons in the U.S.** To be held at the Convention Center, San Antonio, Texas. The program will include continuing education offerings for physicians, dentists, nurses & many other disciplines. There are Meet-the-Investigator presentations, a major core Program, a Combat Medical Readiness Course, Seminars for Nurses, Dentists, Pharmacists, etc. Contact: Mr. T. A. Glasgow, Chief, Corporate Planning, HQ, Aerospace Medical Division, Brooks Air Force Base, Texas 78235; Tele: (512) 536-3656 or CDRT G. McMahon, Asst. Exec. Director, AMSUS, P.O. Box 104, Kensington, Maryland 20795; Tele: (301) 933-2801.

Fifty-Year Physicians

The following physicians received their medical degree in 1931; thereby becoming members of the 50-Year Club in 1981. Recognition will be given during the first session of the House of Delegates.

Arapahoe Medical Society

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C. Wesley Eisele

Boulder County Medical Society

James D. Stewart

Denver Medical Society

Abern E. Bowers
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Larimer County Medical Society

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George E. Garrison

Otero County Medical Society

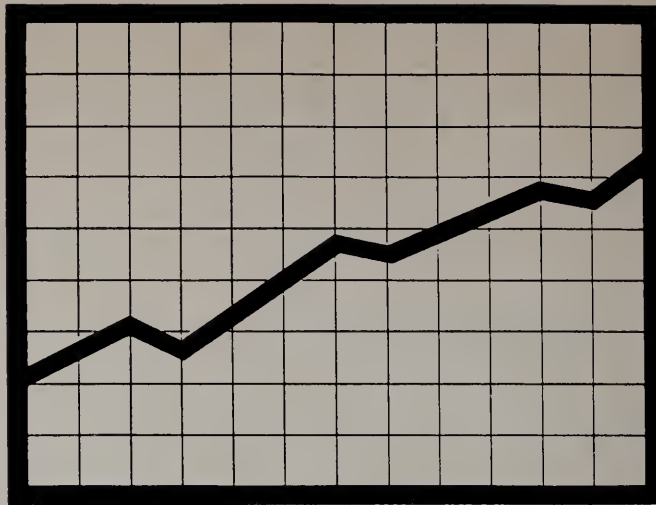
Clayton C. Weber

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The CMS Professional Liability Insurance Trust is the first major step toward a Physician-Owned Captive Insurance Company.

**YOU NEED THE TRUST!
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Call today! Get full details on what the CMS-PLIT means to you! If you have not received the Professional Liability Insurance Trust Program details (an information packet was sent each member in early May), call the CMS office at 861-1221 or (WATS line) 1-800-332-4150!

Every Colorado physician needs the Trust!

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September, 1981

Volume 78, Number 9

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*"Major Issues" for
Colorado physicians
changes in the making
page 336*

*"The Future of Medicine"
and what all of the latest
philosophical and
social changes will mean
page 340*



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Cover Story: It will soon be a world totally of acronyms and "initialization" if we continue the penchant of the '60s and '70s for shortening names, creating agencies and red

tape. These are matters to deal with in the future of medical practice, as Kenneth Platt, M.D., Medical Director for the Colorado Foundation for Medical Care points out in our featured article, "Major Issues Facing Colorado Physicians." The article (pp 336) deals with the PSRO, state-sponsored HMOs, the HMO/IPA, the PPO, the competition mode I, and others. In conjunction with Dr. Platt's observations, please see "Ask Me About Medicine," in our "At Press Time" section, and what other historic and current observers project for medical practice. You may well think up some new, and not so complimentary names to include in our socio-medical jargon.

articles

336 Major Issues Facing Colorado Physicians:

Kenneth A. Platt, MD, Medical Director, Colorado Foundation for Medical Care
Dr. Platt observes that Colorado's physician future is clouded with numerous issues, particularly the change in the PSRO attitudes, the possibilities of PPO, the competition model....what will all this do to your practice?

340 What to Do About The Future of Medical Practice:

excerpts from address by Frederick A. Lewis, Jr., MD, President-Elect, CMS, before the 1981 Annual Session of the House of Delegates.

"A peaceful revolution," with most of the basic governmental philosophies of a half-century being challenged, and the effect on the art and science of medicine. How much difference will your own political conservatism make in the changes?

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features

314 "If The Shoe Fits....." a reprint of a very telling commentary by Gene Amole of Denver. Gene writes regularly for the Rocky Mountain News. On July 30, 1981, Gene's column, "Amole's Corner," started with "Steamed." This may not apply to you or your practice (maybe it doesn't belong here) but it may make you think.

328 Denver County Jail: psychiatric conditions in our jail described by the jail psychiatrist and warden and how these conditions affect the total public safety. A look at the Denver County Jail mental health program in August, 1981.

334 Drug Therapy: Questions & Answers. This continuing series being carried in cooperation with the Rocky Mountain Drug Consultation Center provides information about current tests in arthritis possibly caused by drug therapy.

339 Cyclosporin A: A New Immunosuppressive Agent. Recent research into use of this agent in transplantation, including research conducted by Thomas Starzl, M.D., with kidney transplant patients at the University of Colorado Health Sciences Center, and heart transplantation now and in the future.

COLORADO MEDICINE (ISSN-0199-7343) is published monthly for \$12.00 per year as the official journal of the Colorado Medical Society, 1601 East Nineteenth Avenue, Denver, Colorado 80218. Second class postage paid at Denver, Colorado. POSTMASTER: Send address changes to COLORADO MEDICINE, 1601 East Nineteenth Avenue, Denver, CO 80218. Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizations and other news items relating to editorial content to the Editorial and Business Office.

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"If the shoe fits....."

The following article is reprinted from the Rocky Mountain News, 7-30-81, by request of a CMS member physician.

Amole's Corner by Gene Amole

"No More Waiting"

Steamed.

The longer I sat alone in that little room at the doctor's office, the more my blood pressure went up. Actually, it wasn't my blood pressure that brought me there. It was my stopped-up ear.

I have nerve deafness. Too many wars. Too many loud phonograph recordings in too many radio studios. It is one of these hearing loss problems for which there is no cure. A hearing aid doesn't help. It just makes the ringing louder.

When my case was first diagnosed, the doctor told me to learn to read lips. I haven't come to that yet. I'm OK in one-on-one personal conversation. The phone is no problem. It's the crowded room that gives me trouble.

Cocktail parties are the worst. Words jam together into a formless gibberish. I have learned to smile, nod and utter a little gibberish on my own. As I recall, cocktail party conversation is little more than gibberish anyhow.

My left ear became completely blocked with wax last week. I couldn't hear anything with it, not even gibberish. That's when I made an appointment with my ear doctor.

I had been going to this physician for maybe six or seven years. He is a nice man and a talented doctor. But when I arrived for my appointment, the receptionist acted as though I had never been there before.

She made me fill out new forms about insurance, whom to notify in case of an emergency, where I work, a list of my dependents—all that jazz. I tried to tell her she had the information, but she said there was no record of me.

A triage nurse then filled out more forms about the wax in my ear. Then she put me in a little room. That's where my blood pressure went up. There was one stool, one examination bench and one stainless steel cart with little hoses coming out of it.

A total of 40 minutes had passed and no one had looked at the wax in my ear. I was left to read the instructions on the stainless steel cart and to look at before-and-after photographs of nose jobs the doctor had done.

I got up and walked out. A nurse followed me down the hall, telling me it wouldn't be much longer. I quietly told her that 40 minutes was too long to wait. I knew I had to get out of there before my blood pressure went crazy. I had started to remember all the wasted hours I had spent in doctors' offices over the years, and I really got steamed.

This is not a blanket indictment of all physicians. My regular doctor is very punctual. So is my dentist. But there are some doctors who take the attitude that there is nothing wrong with requiring a patient to spend a half-day just to get 10 minutes of treatment. I am not going to put up with that anymore.

The deadline at this newspaper is 7:15 p.m. If my column isn't ready by then, I get fired. The Federal Communications Commission will take away my radio station if I am repeatedly careless about timing. I have had to accommodate myself to those realities.

I understand that physicians, particularly surgeons and obstetricians, can't always maintain precise schedules. I am willing to give a little leeway. But I'll never again wait longer than 20 minutes for any medical service. Life is too short to spend it reading old magazines.

The bright side to this is that I found a quick, easy and inexpensive solution to my ear wax problem. By the next day, Sunday, I was in real agony. I went to that little walk-in medical emergency clinic at South Wadsworth Boulevard and West Hampden Avenue.

There was a minimum of paper work. A medical doctor and three nurses took care of my problem in a matter of minutes. The whole thing cost 26 bucks. They even filled out my insurance forms for me. There was a little sign on the desk that said I was welcome.

Dear Editor,

In the March, 1981 issue of *Colorado Medicine*, we reviewed the Denver Presbyterian Hospital experience with skinny needle aspiration biopsy. In an effort to further specify cell types of malignant lesions, electron microscopy has been performed on a series of eight malignant cases in which needle aspirate was submitted in glutaraldehyde.

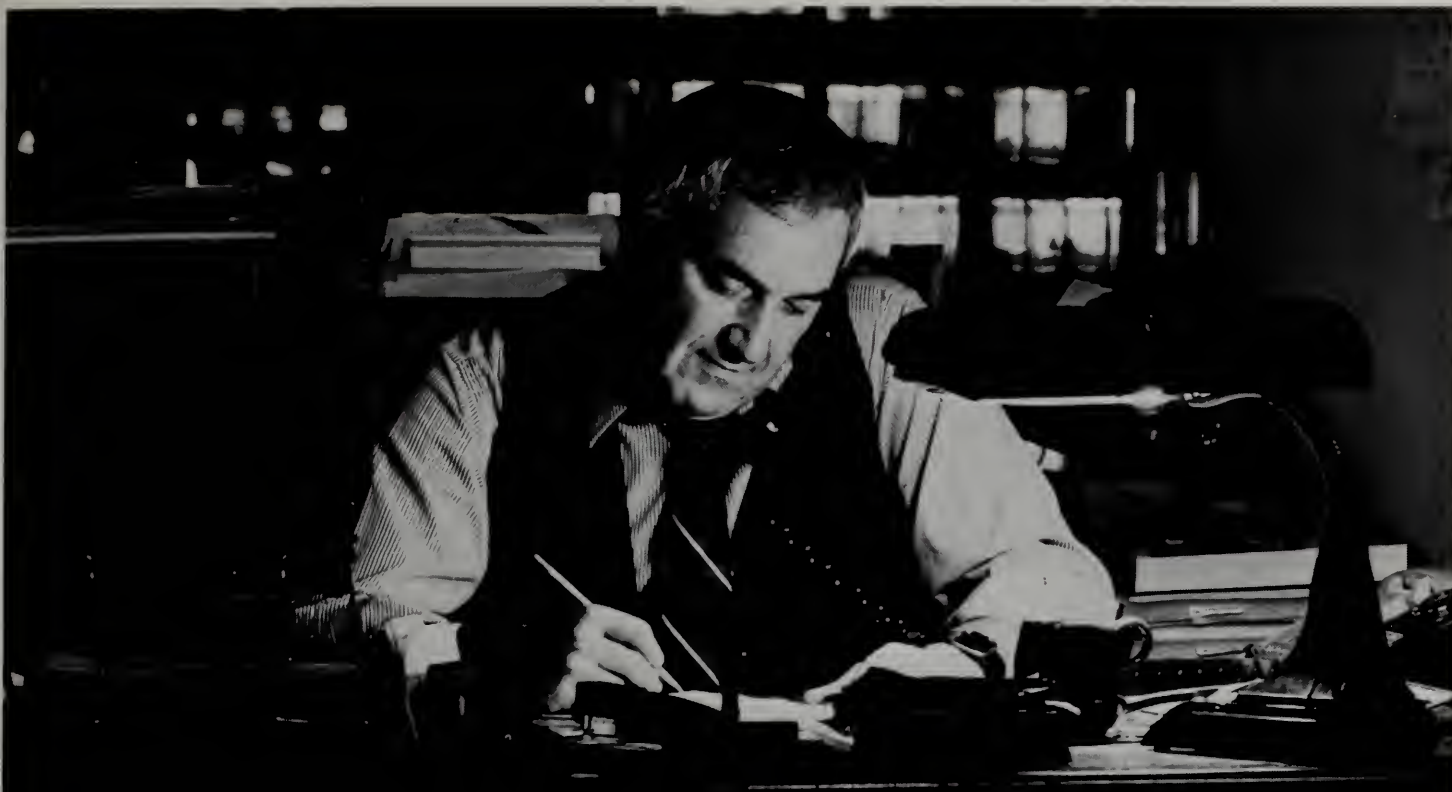
In three (37%) of these, no malignant cells were found on thick section, so EM was not performed. The remaining five cases had good to excellent preservation of the tumor cells. Two of these preparations confirmed the original diagnosis (a liposarcoma and plasmacytoma clinically thought to be a lung carcinoma). However, in one case, a suspected carcinoma was shown to be adenocarcinoma, and in two cases, undifferentiated neoplasms had ultrastructural characteristics of 1) poorly-differentiated carcinoma, and 2) adenocarcinoma. Thus, in three of five (60%) cases with glutaraldehyde-fixed tumor obtained by thin needle, ultrastructural study changed or further specified the cell type of a malignant diagnosis.

We believe that EM should not be considered a routine part of the thin needle aspiration biopsy. However, when cell type is important for further therapy, or to avoid unnecessary surgery, the technique can be of great help.

Sincerely,

Lawrence E. Preshaw, M.D.
Department of Pathology

M.P. Hyman, M.D.
Pathologist



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MATERNAL AND CHILD HEALTH SERVICES

The Colorado Department of Health is applying for federal block grant funds for Maternal and Child Health Services, according to Daniel Gossert, director of the Family Health Services Division of the Colorado Department of Health.

Gossert said it is hoped that \$5.3 million will be made available to Colorado in order to maintain a reasonable amount of service, although the final federal appropriation has not been set.

The application will include a description of the statewide needs for maternal and child health services as well as goals and objectives to meet those needs.

For more information, write the Colorado Department of Health, 4210 E. 11th Avenue, Denver CO 80220 or call 320-6137, ext. 430.

"MILD" HIGH BLOOD PRESSURE SHOULD NOT GO UNTREATED

So-called "mild" high blood pressure should no longer be left untreated.....one of several recommendations in the recently published 1980 Report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure.

The 1980 report integrates new information on the treatment of high blood pressure based on published research and defines some important new emphases in high blood pressure control.

In addition to providing consensus guidelines for detection, evaluation, and treatment of patients with elevated blood pressures, the report addresses nondrug therapies, new drugs for use in stepped-care therapy, the significant role of patient education in therapy maintenance, and management of hypertension in the elderly.

For a free copy of the Joint National Committee Report, write the National High Blood Pressure Information Center (HBPIC), Box JNC 37, 120/80 National Institutes of Health, Bethesda, Maryland 20205.

ASK ME ABOUT MEDICINE

Even if you don't ask me, I'll pass along the following information in the hopes that it will incite you to start asking yourself what is happening to medical practice, and that you will be willing to tell your patients...your public what is happening.

In March, 1981, the CMS Interim Session of the House of Delegates heard Harry Schwartz, noted national columnist and medical observer deliver a severe warning about the collectivization of doctors and the disappearance of the MD as a practicing art and science. Again, in August, 1981, Harry Schwartz wrote in the Wall Street Journal about these same encroaching erosions of the profession: He began his column by saying "The physician as a small businessman and independent entrepreneur, I wrote some years ago, will share the fate of the dodo and the dinosaur. The inexorable trend, I argued, was for the collectivization of doctors, their conversion in the main into hired salaried workers who would join unions and go on strike just like almost everybody else. Writing in 1971, I compared the solo physician of that time with the Soviet kulak of 1928, and predicted the former would share the latter's fate, but through economic pressure rather than the violence Stalin used to collectivize the kulaks.

"....decline or the independent physician continues."

"Since I deplored the trend, I take no pleasure in reporting that the passage of a decade has made my forecast seem much more likely than it may have seemed originally. I return to the subject now in the hope that it is still not too late, and that if society can be made aware of what's happening the trend can be at least slowed."

We needn't dwell on the details because Harry wrote about the same things he reported in his keynote address to the CMS House of Delegates in March (see COLORADO MEDICINE, April, 1981, "Review of Actions"). He stated, simply, that the federal government is still the greatest threat to private practice, fee-for-service medicine, at least in the eyes of many older as well as the younger practitioner.

Let's reflect further....back to September, 1956, when George R. Buck, M.D., the 86th President of the Colorado Medical Society, addressed the House of Delegates. In his acceptance speech, Dr. Buck said "It is in the socio-economic field that our Society will meet problems harder to understand and solve. And it is in the art of medicine, as compared and sometimes contrasted with the science of medicine, that we need our strongest stimulus to continue advancement." What Dr. Buck went on to say was that the practice of medicine was, at that time, one of the few remaining bulwarks of the American private enterprise system, but that it was being eroded by inflation and the loss of ability of the physician to maintain his private practice because of ever-increasing costs of "doing business." Of

course, the statistics he quoted then are almost laughable now:

".....too many patients so that we may maintain a proper standard of living."

As he stated, inflationary pressures on doctors "have forced each of us to see too many patients so that we may maintain a proper standard of living." Dr. Buck added "I cannot blame any individual doctor for shortening his time with patients today. He simply must do so, to pay his trebled and quadrupled overhead costs of practicing, and to pay his doubled costs of supporting his family on anything like the economic level expected of a successful professional man - for what patient, I ask, cares to patronize a shabby and unsuccessful doctor?"

Dr. Buck was saying then -- 25 years ago -- that doctors "can and should educate our patients and the public as a whole to the existence of these problems." Quoting from the then-current statistics, Dr. Buck said "In 1936 a doctor paid \$55.00 monthly rental for a small, but adequate, office in a leading Denver professional building. Today, the same office rents for \$102.50. In 1936 the doctor could hire a receptionist-secretary for \$65.00 a month and a competent registered nurse for only \$99.00 a month. Today, the receptionist-secretary gets \$227.50 and the nurse gets \$300.00. But in 1936 that doctor's fee for an appendectomy was \$125.00 and for a tonsillectomy \$50.00; today the appendectomy is \$150.00 and the tonsillectomy is \$75.00. In 1936 the doctor bought a fully equipped Ford automobile for \$957.00; today a similarly equipped Ford costs him more than treble, almost \$3,000.00. At noon in 1936 he had a fine lunch at the Navarre restaurant, everything from soup to nuts with a choice of eight or ten entrees, for 40 cents; a few days ago I enjoyed the same fine lunch in the same restaurant from an identical menu -- except that the price was \$1.10. In 1936 he charged \$2.00 for an office call and \$3.00 for a home call. His price today are \$3.00 for an office call and \$5.00 for the house call. Again, referring to 1936, I know a certain hospital room which differs today from 1936 in only two respects - new paint and a daily room rate of \$19.50 instead of \$5.00!"

It was in that same speech that Dr. George Buck told CMS Delegates "I strongly recommend that our Society's own members develop a stock insurance company to sell professional liability insurance in Colorado exclusively to members of this Society. I believe such a venture would accomplish two objectives: First, professional liability insurance could be offered at a considerably lower rate than is now available to our members. Second, every stockholding member of the insurance company would realize -- as many physicians too often fail to do under our present insurance system -- that whenever the green-eyed monster of professional jealousy might try to persuade him to disparage another doctor's work without full justification, he would be risking his own pocketbook."

"How does it happen, then, that other statistics show the medical profession at the top of the heap

"....more work for more people, and our output is greater."

so far as prosperity of professions is concerned? That is easy: We are all doing more work for more people and our output is greater. We now allow fifteen minutes to the patient to whom we gave an hour in 1936. We now depend daily on expensive multiple laboratory tests to complete the diagnosis that we made in 1936 by more careful history-taking, more personal physical examinations, and more studied clinical judgement. Scientific advances have over-stimulated and almost pushed us toward 'mechanization of medicine.' They keep luring us away from practicing the art of medicine, so that some of us think of psychosomatic problems, neuroses, and personal and spiritual counseling of patients as new ideas!"

It is interesting to note that one of Dr. Buck's proudest presidential accomplishments was the founding of the Empire Casualty Company, a physician-owned firm which forced national companies to reduce their rates. Dr. Buck was also one of the three originators and incorporators of the Colorado Medical Service (Blue Shield of Colorado). These entities have, just as all other economic aspects of our life, changed greatly from their original form. The point, however, is that leaders of CMS realized then as now that one of the primary hopes for the survival of fee-for-service medical practice still remains with your professional organization, and its success will be greatly tempered by your ability to educate, to communicate the message of medicine to your patients and the public.

"....among their historic predecessors were CHE GUEVARA, MD, and SALVADOR ALLENDE, MD."

As Harry Schwartz stated in his Auguste Wall Street Journal column, "The Decline of the independent physician continues, but as the change proceeds, our society increasingly loses a large group of able and active people who have historically been among the staunchest supporters of free enterprise, economic liberty and all the institutions we lump together as capitalism. This is a period of intense and understandable governmental and corporate concentration on cutting medical costs. But even that can hardly justify a myopia which fails to realize that doctors are being converted from strong defenders of our economic order to a group that will be indifferent about whether it takes orders from private or government bosses. And some doctors, no doubt, will become active advocates of socialism. It is worth remembering that among their historic predecessors were Che Guevara, M.D., and Salvador Allende, M.D."

William Pierson
Director of Communications
Colorado Medical Society

HUMAN ENCEPHALITIS CONFIRMED IN COLORADO

The Department of Health confirmed on September 4th the year's first case of mosquito-borne human encephalitis in a 46-year-old Fort Morgan male, according to Dr. John Emerson, the department's public health veterinarian. The confirmation of western equine encephalitis virus in the patient's blood was completed by the department's laboratory.

Emerson said this illness is transmitted to humans and horses by a mosquito and is not directly transmitted from horses to people.

During the early summer this year the Health Department announced stepped-up control measures for mosquitoes after the virus was identified in horses in Larimer and Elbert County and in young blackbirds in Pueblo County. The disease is, however, seasonal and, as Dr. Emerson indicated, may continue to affect humans through September or until a general frost eliminates the carrier mosquito.

Symptoms in humans are usually fever, eye pain, muscle aches, headaches and a change in mental state or drowsiness, said Emerson.

WHAT HAPPENED TO: THE ROCKY MOUNTAIN MEDICAL JOURNAL?

(Editorial answers to questions which may...or may not...have been asked)

In November, 1979, which now seems like ancient history, the Colorado Medical Society Board of Trustees voted to cease publication of the Rocky Mountain Medical Journal, which had been in semi-monthly publication for a number of years. The reasoning behind this move was: 1) the RMMJ was costing the membership thousands of dollars through a staggering monthly loss, 2) contents of the RMMJ were limited to scientific and clinical articles which could be of benefit to a limited number of physicians, and 3) few physicians outside this small circle of special interest were reading either the Rocky Mountain Medical Journal or the monthly newsletter, "Colorado Medicine."

It was further decided that a single magazine, published on a monthly basis, would carry the information of the society's functions as well as carry a more limited number of the scientific and clinical articles, published for the physicians who submitted for publication. During the first 18 months this worked out with some degree of satisfaction; however, the Board of Directors decided in the spring of 1981 that there was too much information which needed to be distributed to members to allow for continuation of the scientific articles. The immediate reaction of a number of the members was that physicians wishing to publish a scientific article should direct their efforts to the Western Journal, which has long been romancing CMS to let it include a "Colorado" section in its monthly, west-coast magazine. It currently includes a "section" for Washington state, Utah, Nevada, New Mexico, Idaho

and Montana. The "section," however, is limited in size and scope, and deals with general state society news, while scientific articles will be considered by the Western Journal's Editorial Board for publication.

CMS leadership has long felt that the publication of scientific and clinic articles was a luxury the society could ill afford, and was not being of benefit to the greatest number of members. At the same time, the leadership did not want to take away this one more member service. But what to do?

INTRODUCING: THE CMS SEMI-ANNUAL ROCKY MOUNTAIN MEDICAL JOURNAL.

In November, 1981, the first of the "new" Rocky Mountain Medical Journal supplement to Colorado Medicine will be published. This magazine will recapture the beauty and quality of its proud forerunner, with a selection of all-Colorado authored scientific articles. The magazine will have all of the good elements of the former RMMJ, but will be a delight instead of a costly burden. Within a short time a new editorial board will be introduced and we will be accepting (encouraging) submission of articles with consideration for the early summer, 1982, issue.

As is obvious, Colorado Medicine editors plan to publish two issues of the Rocky Mountain Medical Journal each year. The first or "winter" issue will consist of articles which have already been submitted and were accepted for publication prior to discontinuing the publishing of these articles (which occurred with the July issue of Colorado Medicine. The first Journal is going to be big in the sense that there are many articles which have been held for publication but which were not published yet.

The Rocky Mountain Medical Journal is now soliciting your submittal; we are pleased that we are able to offer an even better member/reader service than we have been able to do through Colorado Medicine, and look forward to an outstanding publication. Please let us hear from you!

A DIRECTORY OF PHYSICIANS

Under the Constitution and Bylaws of the Colorado Medical Society, this Society shall, each year, publish a directory of physician members to be distributed to its members in good standing, as of the beginning of the CMS fiscal year (October 1st).

What the purpose of this directory has been in preceeding years is not a consideration at this point. It is important to clarify, at the outset of another year, that the primary purpose of the Physician's Directory, based on informal polling of physician members, should be for a correct and up to date base of information for referrals. Whatever additional gain can be achieved through this listing service is secondary to its main use.

The Physician's Directory will be published in October, 1981, with the most complete information

possible concerning each member. Each member has been notified by letter of this listing service, with a request that the current Directory listing (a sample of which has been included with the letter) be corrected or be approved, as is. This letter asks that the physician correct and return this inquiry sample as quickly as possible. No member has been left out of this inquiry process. Our computerized listing of members, as of September 30, 1981, has produced this inquiry and is dependable in its output. The failings of our 1980-81 Physician's Directory has been wholly in the lack of complete or current information and the unweildy (difficult to use) printout format. Because of the difficulty in obtaining all of the information which should have been in the 1980-81 directory, the computer printout was used in producing the directory. However, it was a first, so there were some failures to be expected.

With the current year, we are pleased to announce that we have the complete, most up-to-date information on each member's practice and will bring the members this information in a wholly readable, appealing style, in a typical "directory" format consisting of the following:

Section 1: Listing of all CMS members, alphabetically, last name first, in the order of their primary practice location (by town and city in Colorado or elsewhere), with up to three additional address listings, specialty practice (up to 5) in the order of their preference by the physician, their component membership (by a code number, since the full name of the component requires too much space to list in each case, i.e., Denver Medical Society appears as "30"), the accompanying telephone numbers for the practice locations and the physician's home address and telephone, if so desired. The component code was previously called the "county code," which is erroneous since the county designation no longer applies to component societies.

The "practice type code" consists of code numbers 1 through 21, indicating private practice, solo; office-based group; hospital staff; administrative; military; etc.

Section 2: Listing of all component members, by component society, referring to the town or city where the physician can be found in Section 1, master listing by primary practice of all CMS members.

Section 3: Listing of all members by their primary practice specialty. In other words, this section will provide persons using the directory an immediate reference to a physician in, say, Grand Junction who is an OB-GYN. If the person is seeking a physician in the Grand Junction area of this special practice, the physician will be easy to find. If additional information concerning the OB-GYN is needed, the section will be cross-referenced with the CMS General Membership and the Component Membership sections. This section will also include, where available, information concerning Specialty Societies in which CMS members are involved, such as current officers, their contact, society executives or

staff persons, etc. If you are a member of a Specialty Society, you are encouraged to have information concerning your society forwarded to our office as soon as possible for inclusion in this reference section.

Section 4: A General Information Section is provided for other details, such as the Colorado Physician's Code of Cooperation, health-related organizations or institutions, hospitals, both public and private, and health and medical care services which are often needed. You will find information concerning the Colorado Medical Society, the Colorado Medical Society Auxiliary, the Colorado Foundation for Medical Care, the Denver Medical Library and other functions of the family of organizations which make up organized medicine in Colorado.

Section 5: Again this year, the Wyoming Medical Society will be a part of the Physician's Directory. It was true, prior to 1980, that we were joined by New Mexico and Montana, representing the total membership of four states; however, New Mexico and Montana chose to produce their own directory during the past two years, and Wyoming's membership is such that they find it more efficient to join Colorado in this endeavor. We are pleased to have the membership in our neighbor, Wyoming, to be a part of this reference work. Their section will stand alone, but will be as complete as is possible in this cooperative effort.

Section 6: Alphabetical Index, which will carry a listing of all member physicians, last name first, in alphabetical order, and reference to the first section where this physician's listing can be found.

If you have further questions about the Physician's Directory for 1981-82, which is now in publication, please contact my office as soon as possible.

Bonnie Van Fleet
Assistant Director of Publications

2nd ANNUAL ROBERT PERKIN MEDIA AWARDS FOR MEDICAL REPORTING

In its second year, the Robert L. Perkin Media Awards for Medical Reporting were presented to twenty-two persons and/or organizations for their superior work during the 1980-81 program year of the Colorado Medical Society. The individual awards were presented by K. Mason Howard, M.D., President of CMS, at the Annual Meeting of the House of Delegates, Keystone, Colorado, September 10, 1981.

The awards program, established by the Public Information Committee of CMS to recognize excellence in medical reporting by individual reporters, editors, producers, publishers and photographers, is named in honor of the late Robert L. Perkin, long-time Colorado writer-reporter-editor. This year's awards went to the following:

Pamela Avery, Medical Reporter, Rocky Mountain News, Denver.

Ruth E. Foster, Reporter, The Weekly Newspaper, Glenwood Springs.

Catherine Evans, Reporter, The Weekly Newspaper, Glenwood Springs.

Debra E. Bender, News Editor, Julesburg Advocate, Julesburg.

David L. Cornwell, Photographer, Rocky Mountain News, Denver.

John Stretz, Producer, KMGH-TV, Denver.

Susan Kinney, Reporter/Producer, KRMA-TV, Denver

Bert Gurule, Reporter, KMGH-TV, Denver

Betsy Dill-Williams, Reporter, KMGH-TV, Denver.

Kim Sherwood, Reporter/Producer, KKTU, Colorado Springs.

Angie Varela-Cole, Photographer, KMGH-TV, Denver.

Mark Olinger, Editor/Photographer, KMGH-TV, Denver.

Jim Sanders, Writer/Producer, KRDO-TV, Colorado Springs.

Phil Fredrickson, Chief Photographer, KRDO-TV, Colorado Springs.

Bill Ruth, Videographer, KRMA-TV, Denver.

Tom Levy, Field Audio Engr., KRMA-TV, Denver.

Roger Crawford, Post-production Video Engr., KRMA-TV, Denver.

Peter Aubry, Photographer, KKTU, Colorado Springs.

Randy Lantz, Photographer, KKTU, Colorado Springs.

Mike Laur, Photographer, KKTU, Colorado Springs.

Saida Pagan, Reporter, KKTU, Colorado Springs.

Three special awards of recognition went to the following organizations for their support in producing useful, worthwhile medical information programs for the general public:

University of Colorado Health Sciences Center, Department of Biomedical Communications.

KMGH-TV, McGraw-Hill Broadcasting Co., Denver.

Public Affairs Department, KRMA-TV, Denver Public Schools.

Robert A. O'Dell, M.D., Chairman of the Public Information Committee of CMS expressed his and his committee members' appreciation for the quality and the quantity of reporting in the public media, saying "I am extremely pleased with the quality of medical reporting which has been published by Colorado print and broadcast media during this past year. There has also been an obvious increase in the number of health and medical related stories published, without sacrificing factual presentation of the medical profession. I congratulate all the award recipients for their creative works in dealing with one of the most difficult subjects. I also wish to thank the members of the judging panel who had a very difficult task in selecting an order of excellence from the many entries."

Ronald Tegtmeier, M.D., added "there were many others who displayed a genuine concern for excellence in medical reporting but, for the limited scope of our efforts to recognize and reward each person, are not mentioned in this CMS award." He went on to say "We hope that future years will see continued increases in quality and quantity of medical information published, which is so important to each Colorado resident."

Edward Duerksen, M.D., also applauded the participants in the award program, stating that it is through this kind of mutual understanding "which develops and makes available the necessary base of information for effective medical reporting. The Colorado 'working press' is to be congratulated for its enterprise in informing the public of vital issues."

Each of the award recipients was presented with individual cash awards as well as certificates connoting first, second, or third place in each of three categories of competition. The awards program is open to all Colorado reporters in the print, radio and television media. The judging panel consisted of a physician, a public health administrator, an independent radio producer, television producer and publisher, all of whom have a combined experience of over 130 years in the field of public health information and journalism.

Colorado Medical Society this year presented two special awards in television. They were to KRMA-TV, public television, for the documentary, "metropolitan Hospital," and to KMGH-TV, commercial television, for the public affairs series, "Medicaline." It was the feeling of the judges and the Public Information Committee that neither of these programs could be judged on the basis of the competitive entries from daily news reporting, and that they were of such a quality that they should be recognized for their contribution to health and medical information and education.

A third award was made to the University of Colorado Health Sciences Center, Department of Biomedical Communications, for their long and excellent contributions to public health information efforts, giving unstintingly of their

scientific and technical abilities. The Department has stood ready to help a wide variety of public and private agencies (including teaching institutions, public and commercial radio and television stations and newspaper publishers) in reporting on the art and science of medicine.

Members of the CMS Public Information Committee are Robert A. O'Dell, M.D., Chairman, (Aurora) Robert B. Sawyer, M.D., (Denver) Ronald E. Tegtmeier, M.D., (Arvada) Edward C. Duerksen, M.D., (Englewood) Gerald M. Hickman, M.D., (Boulder). Liaison to the committee include Mrs. Jerri Fowler, President, CMS Auxiliary (Longmont) and Mrs. Sharon Ritzman, President-Elect, CMS Auxiliary (Golden) Rachelle Kaye, Ph.D., Colorado Foundation for Medical Care, K. Mason Howard, M.D., Immediate Past President, CMS (Arapahoe) Frederick A. Lewis, Jr., President, CMS (Denver) and R. G. Bowman, Executive Vice President, CMS.

THE WORLD OF COMPUTERS, PERSONAL AND OTHERWISE

There have been many developments during the past ten years which seem to be re-directing our society full speed ahead into the world of computers: the October issue of Life Magazine will carry an article concerning the status of the personal computer and its newly assumed role as a standard part of every American household. Our stock market trading is heavily into electronic firms dealing in the manufacture, sales and distribution of hard and software for computers. The era of computer games is drawing more and more people into its grips each day. Trade names such as "Atari" and "Intellivision" are commonplace in daily vernacular, not limited to salesmen or retailers; instead, introducing more and more people into the realm of computers and their versatility as a toy AND as a highly useful tool. Many of our mechanical and structural marvels of today's commerce are being designed and tested on 3-dimensional graphic computer terminals, with the dimensions being projected on the CRT terminal in color. Personal, pocket, reprogrammable computers are stock in trade for many of the technicians, salesmen, designers and constructors traveling to every corner of our nation.

I am neither a computer technician, programmer, scientist nor a very astute student of the art and science of computers. I am, however, practical enough to see what the computer tool can do, even for communications. In the many years prior to Colorado Medical Society seeing the wisdom of computerizing its own membership records, such productions as the Physician's Directory were hand-hewn with voluminous files and cabinets which had to be manually changed and updated with each little ripple in the stream of information. During all the years of the Rocky Mountain Medical Journal, all of the writing, editing and composing was done by staff persons, who then transferred this information to some outside agency for stylizing, typesetting, layout and, finally, for the "camera-ready" page to be placed in front of the photostat cameras and a printing plate to be produced. Then, and only then, did the printing

process begin. All of this magazine editing and makeup took an average of three weeks, and there were still changes which needed to be made before press time. Each author change, each proofing change, each correction, had to be sent back to the outside shop for the changes, necessitating another one, two or three days to complete and have back in the stream. All that has changed with the difference of night and day:

The CMS DEC (Digital Equipment Corporation) Computer now enables the complete computerization of our publication, from front to back, with an average "turn-around" time of 3 days writing, editing, proofing, typesetting, corrections, headlines, picture additions, layout, addition of advertising display art, and to the photostat camera for plate-making. Printing, binding and mail distribution (delivery of the sorted and addressed magazines to the Post Office) can be accomplished in a normal five days. Changes in the final copy can be made conveniently as late as 36 hours before press time. Beginning in October, you will see a magazine which has been composed completely "in-house," meaning that all of the preparatory work prior to actual printing and distribution has been completed in the CMS headquarters. All of this is now in place, is cost-efficient and labor-effective. We will be able to communicate, with greatly increased efficiency, getting the information to you in an appealing, readable and practical manner.

What I have recounted, in the simplest terms, is only a fraction of what the CMS computer system can do and is doing for CMS members. What I have mentioned here is representative of how farsighted the Colorado Medical Society has been in installing the system and, now, making the most effective use of it. There's much more to come, as we learn our way into the computer era. It is neither a game nor a toy.

The person Mile High United Way helps most could be you.

You, or someone close to you, might be benefiting from Mile High United Way without even knowing it. Some of the groups the Mile High United Way supports are Meals on Wheels, Salvation Army, battering and child abuse prevention programs, drug and alcohol rehabilitation programs, senior citizen care, YMCA and YWCA, numerous day care centers, marriage and family counseling, Boy Scouts and Girl Scouts. Mile High United Way touches hundreds of thousands of people each year. Maybe even you.



Mile High United Way
Thanks to you, it works for all of us.



This past year has, without question, been the shortest year of my life: so much has happened within the 365 days I served as your President...all good things, I am happy

to say. This year has given me the opportunity to renew a fellowship and singleness of purpose with my many professional associates throughout Colorado and the nation. The year has given me the vision to see what concerns I share in common with others of my discipline, and to work toward meeting and satisfying those concerns. What I have learned and what I have seen during this year has made me even more determined that mine is the best of pursuits, encompassing service to fellow man and to self, all in one.

I also learned that we, in the medical profession, were not all of a unified position on matters of legislative, social and business consequence. During this past year, however, we have become more

unified. Through the House of Delegates, the council and committee structure of the Colorado Medical Society, we have made, and are making, things happen which will benefit all of the profession and the public we serve for decades to come. Because of the excellence of leadership in each of the component and specialty societies, our purpose and efforts have become more closely allied as a single voice, in a single direction. The just-completed meeting of the House of Delegates has put into motion the reorganization of CMS which I and my fellow

president's letter

officers have worked for. The reconstructed Constitution and Bylaws has made our organization much more effective in the face of continually recurring threats to quality care and the new challenges we meet daily.

I am proud that I could serve the organization in such a time of change, and look forward to being an active member of this society in the future. I am equally proud that our House of Delegates has redirected the course of this organization to better serve all health care needs; this includes the roles of CMS and CFMC as a more cohesive team. The effort can and will be an asset which will appreciate to you over the years.

The coming year promises to be just as short but just as productive for your new President Fred Lewis and President-elect Merlin Otteman. They are, however, prepared, with many innovative programs already under way to benefit the entire organization. I could not leave the office in more capable hands.

I have many things to remember about this past year—more than I will try to enumerate here—but above all will be the patience, help, consideration, counsel and understanding which I received from all of you, CMS members and staff alike, who worked with me throughout the year. Thank you.

Rehabilitation Groups of the American Cancer Society Ostomy Association

With the approval of the attending physician, carefully trained volunteers who have successfully adjusted to ostomy surgery, visit the patient. Personal experience and compassion enable the volunteer to communicate emotional support. No medical advice is given.

For more information

American Cancer Society
Colorado Division, Inc.
321-2464

K. Mason Howard, M.D.
President, CMS

Durango Physician Honored for 45 Years Service

Leo Lloyd, M.D., was honored with a testimonial dinner, by the Board of Directors of the Mercy Medical Center and the La Plata County Medical Society for his 45 years of medical service. All five of his sons and Congressman Wayne Aspinall attended along with many other guests.

Dr. Lloyd was presented with a plaque from his peers, "In appreciation for 45 years of dedicated service to people in the area." The plaque was presented by Michael Lawler, administrator of Mercy Medical Center, on behalf of the medical center and the physicians.

During the presentation each son spoke of his father and his devotion to his family. In spite of his extremely busy life, Dr. Lloyd always had time for his children.

Dr. Craig Edgerton, president of the La Plata County Medical Society spoke of Dr. Lloyd's excellent example for all the physicians in Durango, both old and new, during the 45 years he had practiced. Dr. Lloyd is recognized statewide and nationally as he has served on both the Colorado Board of Medical Examiners and the national board. A letter was read from Gov. Richard Lamm by Lawler which thanked Dr. Lloyd for his years of service in state medical

Other speakers were Congressman Wayne Aspinall, Dr. T.W. Halley, his associate for almost 30 years; and Michael Hogan, president of the board of Mercy Medical Center. Robert Beers was master of ceremonies.

Dr. Lloyd was born in Palisade on August 6, 1909. He received his bachelors degree at the University of California in Los Angeles and his medical degree from Washington University, St. Louis, Missouri.

He married Mary Elizabeth Sheedy June 18, 1935, and has five sons, Leo W. Jr., Daniel R., Thomas P., James J., and Matthew J., and one daughter, Mary Elizabeth.

Dr. Lloyd has served on the CMS Board of Censors (1946-52); the CMS Judicial Board (1949-55); as Secretary of the Colorado State Board of Medical Examiners; as a member of the District 9-R School Board (1948-55); and as Vice President of the Colorado Medical Society in 1956. He is a member of the Colorado Medical Society, the American Medical Association, the Lions Club, and a Fellow of the American College of Physicians.

In the past Dr. Lloyd has received such honors at the Gold Heart Award from the Colorado Heart Association (1957) and the Distinguished Service Award from Fort Lewis College (1970). He has also written an extensive number of articles for medical and non-medical publications.

Dr. Lloyd is not retiring from the practice of medicine. The dinner was given at this time as a tribute from his peers to one of the leaders in Durango.

Component Report Medical Students

Donald Putzier, MSII,
Vice President

The Student Medical Society has begun numerous activities for the 1981-82 school year. We are pleased to welcome the new freshmen to the University of Colorado School of Medicine, as well as new members of the Society.

A weekly course in American Sign Language began on September 2 at the Medical School. Communication between the health professional and the hearing-impaired is stressed. Those interested in future offerings of the course should contact Mary Ruth Salazar at 343-0283.

The Society sponsored its first blood pressure screening of the school year with the American Medical Student Association, the Denver High Blood Pressure Clinic, and the American Red Cross. The September 19 screening at the Safeway Store, 6220 E. 14th Avenue in Denver provided a service for the community, as well as training for medical student volunteers.

We are honored in presenting Frank Reed, M.D., to address students at the medical school on Wednesday, October 7, at 12:00 Noon, in the second floor lecture hall. Dr. Reed will speak to the students concerning small-town family practice. Dr. Reed practices in Bailey, Colorado. He has operated the Crow Hill Family Medicine Center for four years, and will discuss its operation, staffing and facilities.

We welcome service and expertise from physician members of CMS throughout the year. Those interested are free to contact me at 355-5763.

Health Insurance at Sensible Rates for Colorado Physicians

A health plan which is unique among health plans in the United States is being offered exclusively for the Colorado doctor, his/her family and employees. It has been designed by and for members of the Colorado Medical Society. The benefits and rates reflect substantial savings and increased coverage applicable to today's medical profession.

The Colorado Foundation Trust Board of Directors for the Colorado Foundation for Medical Care expanded its Group Health Plan to allow for inclusion of all members of the Colorado Medical Society (Effective February 1, 1981).

While other health plans have found it necessary to substantially increase their premiums, participants in the CFMC Trust have experienced little adjustment in rates but with increased benefits in areas of indicated needs over the years. The Foundation, as Claims Administrator, constantly monitors the Group Health Plan and gives direction where indicated.

Traditionally doctors have been lumped into "boiler plate" programs with rates and coverages applicable to groups other than the medical profession. Careful study and experience has shown the rates previously charged doctors and their employees are figured at a rate

higher than actually necessary.

The Colorado Foundation for Medical Care, because of its excellent staff and claims handling, has eliminated most of the problems found in other plans and has been able to provide to the doctor utterly free of worry when a claim arises. Not only does a program run smoothly when this service is provided, but an up-to-date communication system is constantly monitored between the doctor, hospital, pharmacy, and service agencies.

No health questions are required when a group of 6 to 10 enroll 100% of eligible participants, or groups of 11 through 49 have 75% of the eligible participants enrolled. The new life rates, recently approved, have even more liberal underwriting.

Grievance of the Month

Complaint: "Why should I pay Dr. Helper? I never hired him, never heard of him and never even talked to him. I'll admit his bill was not large; but was it necessary?"

Investigation: Mr. Truss was relating his reaction to a bill he received after going into the hospital for a herniorrhaphy. The surgery was uncomplicated, his hospital stay short, and his return to work rapid. Unfortunately, his surgeon had neglected to tell him that, for the patient's own safety, he would need an assistant during the operation. Should the hospital not have any house staff available, his doctor might well ask another doctor to help out, and thus, there would be an additional fee—not uncommonly 20% of the surgeon's fee.

Disposition: The surgeon in question was advised that, to prevent this grievance, the possibility of his requiring an assistant should have been pointed out to his patient, Mr. Truss, prior to performing surgery.

Such benefits as room and board are 100% of average semi-private. Covered hospital expenses are 100% for the first \$1,000, then 80% to \$5,000, and back to 100% up to the plan maximum of \$250,000. Surgery, anesthesiology, and medicine have been increased to meet today's factors. These are just a few of the highlights of a plan that is first and foremost our plan, reflecting what we feel are more advantageous rates to the medical profession.

Recognizing that other health care plans have experienced premium increases, the Colorado physician may wish to closely review the excellent health care plan offered through the Colorado Foundation Trust.

The Cooney Agency is the Administrator of our Health Care Plan and as our representative, is responsible for negotiations with the carriers at our direction. They are located at 1922 East 18th Avenue, several blocks from the Colorado Medical Society's headquarters. For information concerning insurance programs offered the CMS and/or CFMC member physicians, please contact the Cooney Agency at 388-0854 collect.

Alcoholism Treatment: Intervention

"Last night you came home from work at 10:30 and you're off at 5. You were so damn drunk you fell off the front porch and sprained your wrist. On Saturday, we had to leave your boss's party when you drank too much and started telling obscene jokes. And in March, we had to pay a \$100 fine for your drunk-driving conviction.

"Look, I don't want to say this, but I've had it. If you'll get treatment for your drinking problem, I'll stick with you and try to help. If not, I'm moving out. It's up to you."

Is this the voice of an overwrought shrew or a compassionate wife? Is her ultimatum more likely to move her alcoholic husband to seek treatment or to drive him to drink all the more? And doesn't an alcohol addict have to decide on his or her own to get help before it

can do any good?

The answers to all these questions have changed in the past few years as evidence accumulates that pressure at home and at work, properly applied, can be the most effective way to get an addicted drinker to seek treatment for the disease of alcoholism.

Increasingly often, counselors and health professionals are realizing they shouldn't wait for the alcohol addict to come to them voluntarily. The sooner the victim is treated, the better the chance for recovery—no matter how or why s/he sought treatment.

Many hospitals and treatment centers now offer what are called "intervention programs" for those close to the addicted drinker. These programs train people to stand up to the alcoholic, to list specific instances of problems or injuries caused by drinking rather than general accusations and to encourage him or her to seek help.

"The key to intervention is consequences", says Erick M. Davis, M.D., medical director of Schick Shadel Hospital, and alcohol-addiction treatment facility in Seattle. "As long as someone covers up and makes excuses for the person whose drinking is out of control, that person has no incentive to change.

"The person who ceases being an 'enabler' must not feel guilty," Dr. Davis adds. "After all, they're not causing the drinker to miss work or wreck the car—they're just not hiding it anymore."

Other authorities agree.

"The protecting and accommodating gives the illness free reign to progress with no obstacles in its path," writes Robert Morgan in *Alcoholism: The National Magazine*. "Families are doing the best they can with what they know, but in actuality they are often hurting the alcoholic.

"Unchallenged, the alcoholic has his disease progress farther and farther into its more serious stages. Shielded from realizing the problems caused by his drinking, he is blinded to the harmful effects it is causing him and those around him, and so there is no reason to do anything about it."

Once those close to the alcohol
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addict have stopped denying there is a problem, they can begin to persuade the one who has the problem. This is often a difficult task at best, given the inability of the alcoholic to remember the negative consequences of his drinking.

Alcohol can cause real blackouts that may last for minutes, hours, or even days. In addition, psychological blackouts can erase intolerable memories—the alcohol addict wakes up with a crushing hangover and vague anxieties but no distinct recall about the night before. Someone who can't remember what harm or embarrassment s/he has caused isn't likely to recognize the need to change their drinking behavior.

Families, therefore, are told to write down the dates and times of the addict's offenses and to be cool, factual and very specific in their complaints. Instead of being judgmental and saying, "You always come home drunk looking like a bum," they are doing more good if they say something like, "You came home drunk at midnight last night with mud all over your coat."

While interveners may think their itemized list of grievances is painfully obvious, it is likely that the alcohol addict doesn't realize the full extent of his or her problem. A fuller realization may come only from putting together the separate "I just had a few drinks" occurrences into a pattern of excessive drinking.

It may take weeks of counseling and "rehearsals" before those close to the addicted drinker feel confident enough to confront him or her. Before that confrontation, they arrange either to get the drinker into a treatment center or to leave home themselves, if that's the decision they have reached.

By the time they deliver the ultimatum, they have the alcoholic's bags packed and hospital reservations made—and they have their own bags packed too, just in case. But faced with the choice between losing family and friends or getting help, most alcohol-addicts will opt for treatment, though unwillingly at first.

As Dr. Davis points out, "Alcohol addicts in advanced stages of the

disease are in no condition to look at the problem clearly and make a rational decision. Someone has to step in and say, 'This person is too sick to save himself.' Then, the compassionate thing to do is to confront, not protect."

Effective alcohol treatment hospitals are able to alter consequences of their drinking behavior on their health and social relationships. The alcoholic learns to associate drinking with the unpleasant consequences that result from it. The best role for the intervener really isn't to attempt to motivate the alcoholic to stop drinking. Their challenge—and the hope for the alcoholic—is for them to get the addicted drinker quickly into a treatment program.

Morgan adds, "The motivation (to quit drinking) comes after the person starts to get well."

National Treatment Center for Child Abuse Named After its Founder

He has been described as the leading spokesman for a large but silent minority—the abused children of the world. For more than 20 years, C. Henry Kempe, M.D., has devoted himself to improving the plight of physically, sexually and emotionally abused and neglected children and their unhappy parents.

In 1972, Dr. Kempe founded the National Center for the Treatment and Prevention of Child Abuse and Neglect, a part of the University of Colorado Health Sciences Center. On Thursday, August 20, the CU Board of Regents named the center, located at 1205 Oneida St., after him: the C. Henry Kempe National Center for the Treatment and Prevention of Child Abuse and Neglect.

A professor of pediatrics, Dr. Kempe, 59, has been director of the Center since its founding. On September 1, he and Richard D. Krugman, M.D., will become co-directors. Dr. Krugman has been the director of the Health Sciences

Center's SEARCH (Statewide Educational Activities for Rural Colorado's Health) program.

Dr. Kempe first became internationally famous for his studies and pioneering contributions in immunology and infectious diseases. In the late 1940s, he first studied some of the serious complications of smallpox vaccine. He subsequently developed a vaccine which became the standard agent for use in the prevention and treatment of the complications of smallpox vaccinations.

Another of Dr. Kempe's noteworthy contributions occurred in 1958 when he called attention to what he termed "the battered child syndrome." He described the syndrome; showed how to manage families in which the condition occurred; pointed out how to assess, evaluate and treat the children who suffered child abuse, and eventually developed the guidelines used in predicting where child abuse may occur so that measures could be instituted to prevent it.

Today, his recommendations regarding child abuse have been incorporated into legislation that has been adopted by almost every state in the country. Thousands of child protection teams worldwide are modeled after the one he started. The C. Henry Kempe center trains professionals in multidisciplinary fields to deal with all aspects of child abuse.

As chairman of the CU Department of Pediatrics from 1956 to 1973, Dr. Kempe brought the department from almost complete obscurity to a position of prominence which served as a model for many other departments throughout the country.

From his department, important information emerged concerning the care of low birth weight infants, standards of development of the young child, the training of pediatric nurse practitioners, and the elucidation of a variety of metabolic disorders and immunologic and infectious diseases.

Among Dr. Kempe's many other contributions was a simple in-hospital residential arrangement whereby a parent could stay and help in the care of a sick child. He also brought in foster grandparents

before the federal government began subsidizing such programs.

Dr. Kempe has received numerous awards and honors, some of which are the Fulbright Professor of Pediatrics and Virology in Rome, member of the Expert Committee on Smallpox of the World Health Organization, consultant to the Surgeon General of the United States, president of the American Pediatric Society, and many others.

Last May, the C. Henry Kempe Club and Scholarship Fund was created at the CU Health Sciences Center. Thus far, more than \$75,000 has been donated.

Central City Honors John Fleming



John Fleming, M.D., radiologist at St. Anthony's Hospital, was honored by the Medical Friends of Central City for his outstanding contributions to the Central City Opera Association. This is the first such award given by the Medical Friends, a group of opera and musical theatre enthusiasts among physicians of Colorado.

Dr. Fleming was recognized for his long-time membership in the Director's Club, his active membership on the Board of Directors of the Opera Association for over 20 years, for his countless hours in restoring and helping to maintain the historic properties of the Association in Central City. In presenting the award, Ronald Tegtmeier, M.D., of the Medical Friends of Central City, said "Dr. Fleming is a licensed electrician, and has labored through sum-

mer and winter to preserve or restore the electrical systems in many of the grand victorian mansions." Dr. Tegtmeier added that this award will be given, annually, to a physician, physician's spouse, or other medical person who makes outstanding contributions to the Central City Opera Association. The Association celebrates its 50th anniversary in 1982. The Central City Opera Association annually produces the summer festival in the Central City Opera House, this year featuring opera and jazz. The Association owns one-third of Central City and, thereby, is the major force in preserving Central City as the finest example of victorian gold rush days in Colorado, if not in all the United States.

Each summer, the Central City Opera Association conducts an apprentice artist program, consisting of a 2-year apprenticeship through the American Guild of Musical Artists. Apprentices chosen to participate in the program work on main stage operas and in 1-act operas. In addition, they are given workshops on diction, movement and acting. They are also given classes in stage makeup and participate in seminars.

(Continued on next page.)

Help Available For Impaired Physicians

The CMS Impaired Physician program is available to help physicians before they become a danger to self or patients.

A few years ago the House of Delegates directed the Board of Trustees to create a program designed to help physicians with impairments to confront their problems and to find effective treatment. The approach of the Physician Health and Rehabilitation Committee is as an intervenor and not disciplinarian.

Those who believe they may have a problem or know of a colleague who may have a problem may contact the Committee at the CMS office in Denver, 861-1221.

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The Central City Opera apprentice program is one of four in the United States, and apprenticeships are much sought after by aspiring artists.

ACS Holds Cancer Conference

Updates on radiation, Chemotherapy and conservative vs. radical surgery were the topics at the recent Rocky Mountain Cancer Conference titled "Controversies in the Management of Breast Cancer."

The 230 doctors, nurses and allied health professionals in attendance for the one-day meeting at the Sheraton Denver Tech Center heard the authorities on the different forms of treatment plead their cases for the management of the ten diseases that make up breast cancer.

The faculty for the conference was lead by Gianni Bonadonna, M.D., a leader in the use of adjuvant chemotherapy for the treatment of breast cancer, from the Instituto Nazionale di Tumori, Milan Italy. Also speaking were Jay R. Harris, M.D., Clinical Director at the Joint Center for Radiation Therapy, Harvard Medical School, Boston; David W. Kinne, M.D., Associate Attending Surgeon and Chief of Breast Service at the Memorial Hospital, New York City; and Steven Silverberg, M.D., Professor of Pathology at the University of Colorado Medical School in Denver,

Nicholas DiBella, M.D., Conference Chairman and Chief of Hematology-Oncology at Fitzsimons Army Medical Center, said the conference dialogue "went a long way in clarifying the status of the different forms of treatment and their indications."

Drs. Bonadonna and Harris spoke in favor of a form of treatment for small cancerous tumors which involves the removal of the lump followed by radiation and chemotherapy. Dr. Bonadonna cited a 1973-80 study at his institute in which half of the 701 patients received a radical mastectomy and the other half a quadrantectomy

(removal of the quarter of the breast with the tumor) followed by radiation. He said there was no difference in the survival between the two groups eight years after surgery.

Dr. Kinne, a spokesman for the modified radical mastectomy said not enough time has elapsed to adequately judge the success of the more limited surgery.

Dr. DiBella said the conference, which was sponsored by the Colorado Division of the American Cancer Society, the Colorado Medical Society and the Colorado Society of Osteopathic Medicine, summarized recent progress in the management of breast cancer. He added, "As always, no one form of treatment in and of itself is always the right one. Each of the modalities (forms of treatment) have their own and specific advantages."

Denver County Jail

The Denver County jail is the first of very few in the nation to merit accreditation by the American Correctional Association. Nevertheless, serious and disturbing problems exist in the jail according to Dr. Glenn E. Swank, jail psychiatrist and John Simonet, Warden.

Dr. Swank says that inmates who need psychological help are not getting any at all. He conservatively estimates that there are 25 inmates confined to the jail who are severely and chronically mentally ill and in need of long term hospitalization. Resources for treating these inmates are presently limited to psychotropic medication. Of serious concern to Warden Simonet is the fact that nearly two-thirds of these inmates have been confined for as long as six months. Most are being held for misdemeanor and minor charges for which bond was set as low as \$100. These inmates were deemed to be incompetent to enter a plea in court. They are presently waiting psychiatric evaluation or commitment to an institution. Such inmates may sit in their cells for as long as six months before the commitment process is completed or the space is available for their commitment to an appropriate facility.

The mental health observation ward of the Denver County Jail is a disgrace according to Simonet. Severely disturbed inmates are placed in solitary confinement, without even a toilet, only a hole in the floor. They may be so disturbed that they are not even allowed to keep a paper cup of water in their cell. Such individuals do not belong in the county jail which lacks the appropriate resources to treat the inmates or confine them in a humane manner. Simonet sees the Denver county jail increasingly becoming a holding facility for the mentally disturbed until they can find a way to be committed.

The fault, if fault can be cast, is not the city and county of Denver's. The fault lies in our state legislature. Budget cuts have reduced bedspace in locked facilities for the mentally ill and eliminated mental health programs. Also contributing to the problem is the fact that individuals charged with misdemeanors and violations of city and county ordinances cannot be criminally committed, but must be civilly committed. This lengthy process, during which the inmate is frequently unable to post bond, is held in the county jail.

Dr. Swank believes the state needs two improvements in order to handle properly the mentally disturbed. First, he says, the state needs to provide more long term treatment facilities for the mentally ill. Secondly, there is a need for stricter mental health laws. Dr. Swank feels the Colorado mental health laws are too liberal. They actually bar people who need help, he says. Legislators are too worried about the protection of citizens' civil rights, rather than guaranteeing treatment to all who need help. Warden Simonet stated that our legislature needs to provide more beds and locked facilities, rather than cutting out mental health programs.

Our mental health programs are important to the safety of everyone in the state of Colorado. Talk to your congressman and learn what you can do to help your state.



President of the CMSA in April of this year.

The AMA Auxiliary was founded in 1922 with one basic purpose: to promote quality health and health care for all by concerned physicians'

Just what is the purpose of the Auxiliary? What does the Auxiliary really do? Do these questions sound familiar? Many of you reading this have asked me just this since I became

spouses. The Colorado Auxiliary was organized the same year and serves as the coordinator between the national auxiliary and the county auxiliaries where all programs are implemented.

Since its modest beginning almost 60 years ago, the Auxiliary has continued to grow to accommodate a burgeoning population across our nation. With 81,000 members at present, thousands of programs are implemented each year by component auxiliaries at grass roots level in our communities. These include fund raising activities to support the

American Medical Association-Educational and Research Foundation. Last year alone, \$1,692,346.03 was disbursed to medical schools and universities of our choice throughout the United States. Community blood drawings, Health Fairs, vision screening, child immunization, health education in schools and participation in pertinent health legislation have been, and some still are, part of the programs.

With the spiraling cost of health care our voluntary effort is perhaps more critical now than ever before. The Auxiliary will continue to pursue its goal of quality health and health care for all. The consumers of the 80's must accept more individual responsibility in maintaining a lifestyle from which they can realize the optimum in health and wellness.

Our medical auxiliary involvement is just one facet of a many-faceted civic effort. We are not an extension of our spouses, but individuals with a wide diversity of interests, talents and education. Our voluntary efforts complement, not compete or conflict with our spouses profession. This can happen only when you, our spouses, recognize and support the thousands of volunteered hours we give, as a meaningful contribution to our communities.

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Nutrition and Medical Practice Reviewed

Nutrition and Medical Practice, Compiled by Dr. Lewis A. Barness and co-editors is an excellent summary of the role of nutrition in many areas of medicine. It is the result of a special issue of the *Journal of the Florida Medical Association* published in 1978-1979 and has been updated and revised to a textbook format. The editors have expertise in the fields of public health, pediatrics and endocrinology. They have enlisted the other areas such as Dr. Bray in obesity, Dr. Kaminsky, Jr. in total parenteral nutrition and Dr. Herbert in vitamin therapy.

The book consists of 32 concise chapters covering a wide range of topics from the school lunch program to nutrition in renal failure. Each chapter is adequately referenced with some as current as 1980. An additional bibliography at the end gives source material for patient reading. Numerous tables provide information about food content, growth curves and nutritional requirements.

Any book about nutrition must address the controversial fads and this book does this well. Dr. Bray unequivocally states that human chorionic gonadotrophin is a placebo when used for obesity and that jaw wiring and bypass procedures are applicable only to obese patients with other medical problems that are significantly aggravated by obesity. Dr. Herbert makes equally emphatic conclusions in his sections entitled "Vitamin C Megadoses—Thumbs Down" and "The Laetrile Fraud."

One criticism of this book is the frequent repetition of the methods of nutritional assessment. It would have been better to review this in a single chapter and leave the other chapters to discuss unique aspects of nutrition in each condition.

Overall, this book provides an excellent summary of nutrition for medical, paramedical and lay personnel. Though it is unlikely that anyone would read the entire book, most will find some area that is both interesting and useful.

Oral Cancer, edited by Sol Silverman, Jr., M.A.D.D.S. All aspects of oral cancer are discussed: epidemiology, etiology, premalignant factors and prevention, diagnosis and treatment. A chapter on the rehabilitation of oral cancer patients includes discussion of reconstructive surgery as well as the management of dysfunctions in speech, chewing, swallowing and saliva control.

The chapters on etiology, diagnosis and treatment focus mainly on squamous cell carcinoma, by far the most common form of oral cancer. Additionally, head and neck cancers are discussed, as are the leukemias, lymphomas, and other malignancies that often have oral manifestations or complications.

The importance of the dentist's role in the detection and treatment of oral cancer is emphasized. Dentists have a unique opportunity to detect oral cancers during routine examination of the mouth or as the first clinicians consulted for oral complaints. In addition, patients

with oral cancer require special dental care.

A donation of \$.75 is requested because of the size of this volume.

Prostate Cancer: Continuing Progress, by Gerald P. Murphy, M.D., D.Sc. This publication replaces *Prostate Cancer: Progress and Change*.

Prostate cancer is the third leading cause of cancer death in men. In this article, the author points out that current data substantiate the view that black American males are at high risk of developing the disease. Dr. Murphy provides physicians with a comprehensive overview of the status of various methods used to detect, diagnose, monitor, and treat prostate cancer. The topics discussed include: changes in the staging of prostate cancer, mechanisms of spread, advances in assays used to measure serum acid phosphatase levels, the search for other biological markers, tumor receptor content, serum testosterone levels, preferred forms of primary treatment, and palliative therapy. The text is supplemented by a number of tables and figures that summarize clinical data.

Library News

Effective October 1, 1981, the National Library of Medicine will increase its connect hour charges for on-line access to its data bases. This increase will allow NML to recover operating costs associated with providing the on-line service. The DMS Library will also adjust its charges as of October 1st. Searches performed on the on-line portion of the data base (1977 to present) will cost \$8.00 for CMS members and \$12.00 for other requesters. A search which also includes the back files (1966-1976) will cost \$12.00 for CMS members and \$16.00 for all others.

Consortium Update

The Colorado Consortium for Continuing Medical Education will complete the last of three demonstration years in December, 1981. During the last few months, the Board of Managers of the Consortium, consisting of two members each from the Colorado Medical Society, the Colorado Foundation for Medical Care and the University of Colorado School of Medicine, met to work out a plan for the future.

After considering several options, the Board decided unanimously to recommend establishment of a Forum on Continuing Medical Education to succeed the Consortium, effective January 1, 1982. As envisioned by the Board, the forum would have more sponsors than the Consortium, would charge only a small membership fee (if any), would rotate chairmanship of meetings annually, would have no staff of its own, and would serve as a means of communication among Colorado organizations that sponsor CME programs and activities.

Over the past three years Consortium projects have included the publication of the *Continuing Medical Educators' Handbook*, the CME teleconference series, a series of programs on alcoholism and drug abuse (under contract with the Colorado Department of Health) presented to six community hospitals, and the *Directory of Clinical Topics for CME planners*.

Other projects on which the Consortium staff is currently working include a statewide conference on continuing medical education and a handbook for physicians on how to select, evaluate and use computer systems in their offices.

Physician Data System

Physicians, even in remote areas, will have access to a new nationwide electronic medical-health information system on a demonstration basis in 1982, and as a regular service soon after. The American Medical Association and GTE Telenet Communications are developing the system, which will use GTE Telenet's "packet-switching" data network. The network reduces communication costs

through the simultaneous transmission of data from many users over the same circuit.

According to the contract between the AMA and GTE, the AMA will provide the medical-health information for the data base, while GTE will develop the data base retrieval system.

The physician or other user will be able to gain access to the medical information data by dialing a local telephone number. He or she will link his computer terminal, via GTE's data communications network, to the company's computer in Virginia. Requested information will be transmitted within seconds and displayed on the user's terminal.

Organizing structure for the infor-

mation system will be the well known AMA publication *General Medical Information Terminology* (GMIT).

Computer Handbook Project

A hand book on computer use for physicians is the newest project of the Colorado Consortium for Continuing Medical Education. The staff and advisory task force are working together on the handbook, which is targeted to be distributed by the end of December 1981.

The handbook will have sections
(Continued on next page.)



Sanford D. Peck, M.D., Department of Pathology, Presbyterian Medical Center, Denver, prepares to give his presentation "Pitfalls in Anti-Coagulant Monitoring" at the May 15th teleconference sponsored by the Colorado Consortium for Continuing Medical Education. With Dr. Peck are Elmer Koneman, M.D. of the Colorado Association of Continuing Medical Laboratory Education (CACMLE), Kevin P. Bunnell, Ed.D., Executive Director and Sheila C. Swan, Program Assistant for the Consortium.

(Continued from previous page.)

on subjects like how the physician can decide whether he needs a computer in his office, an annotated questionnaire he can use to query vendors about their services, a bibliography of computer information sources and computer consultants, as well as a glossary of computer terms, and a directory of vendors who serve the Colorado area.

Members of the advisory task force are: Susan Clark of the Colorado Medical Society; Andrew Kramer, M.D., of the Office of Rural Health; Jay McKiernan of the Colorado Hospital Association; William Middlebrook of The Software Place; Roger Simmons, M.D., of the CEIS Computer Center; and Gerald Meltzer, M.D., and William Braithwaite, M.D., of the University of Colorado Health Sciences Center.

Resource Center Dedicated

On July 10th. Kevin Bunnell, Director of the Division of Continuing Education and Public Health of the CMS, officially the new learning resources Center at the Veterans Administration Medical Center, Fort Lyon with these words: "I now dedicate this Learning Resources Center. Use it to be as good as you are capable of becoming."

The Fort Lyon facility was given provisional accreditation to award accredited CME hours in January, 1979. At that time, the team that surveyed the hospital noted several deficiencies. Rather than being dismayed with the deficiencies, the Education Committee, and its staff person, Kenneth S. Russell, Ed.D., Associate Chief of Staff for Education, looked upon them as a challenge for its resurvey in 1980. Thus, the concept of a new wing wholly dedicated to the education of not only the medical staff, but the physicians of Southern Colorado, was born.

With the support of the Veterans Administration and the administrative staff of the Fort Lyon VAMC, the Center has become a model educational facility. It offers two large classrooms, a conference room, medical library, audio-visual preparation room, 35 mm cameras, videotape cameras and players, slide projectors, complete projector/recorder equipment, microfilm readers, satellite ground station, and MEDLINE search terminal.

Dr. Bunnell presented the hospital with a framed letter of congratulations from CMS president, K. Mason Howard, MD, with the challenge that they carry forth their long standing mission of using the science of medicine to treat and cure the sick,

and to return them to the community and productive lives when possible.

Committee on Accreditation

Highlights of Minutes April 20, 1981

The Committee awarded full CME Category 1 accreditation to the following hospitals and medical specialty societies: Colorado Dermatological Society (four years), Colorado Psychiatric Society (four years), St. Mary-Corwin Hospital, Pueblo (two years), Swedish/Porter Hospitals, Denver (four years), and Rose Medical Center, Denver, (two years).

The Committee approved final changes to the accreditation policy statement, which will now go to the CMS Board of Directors for approval.

Staff reported that the four hospitals in the San Luis Valley are planning to form a consortium for CME which will apply for accreditation. The San Luis Valley Area Health Education Center will provide administrative services for the consortium.

Highlights of Meeting of the Board of Managers Colorado Consortium for Continuing Medical Education (CCCME)

The Board of Managers met on July 10, 1981 at the University of Colorado School of Medicine.

Topics of discussion included the Consortium's Teleconference project and Alcoholism and Drug Abuse Program. Approximately 120 people have taken part in the first three teleconferences. Response to the programs has been very good, and tentative plans are being made to continue this service to primarily rural physicians in the fall.

The Consortium has also made a contract with the Colorado Department of Health to present a series on the office treatment of alcoholism and drug abuse in patients. Arrangements are being made to present this program at several hospitals.

The next meeting of the Board was scheduled for July 13th.



Kevin Bunnell, EdD, Director, CMS Division of Continuing Education and Public Health; Kenneth S. Russell, EdD, Associate Chief of Staff for Education, VA Medical Center, Fort Lyon; Wayne Whiting, Acting Director, VA Medical Center, Fort Lyon; Dodd Greenleaf, DO, Chief of Staff, VA Medical Center, Fort Lyon.

CME/Rural Health Conference

Larry Weed, physician and noted expert in the field of medical computer technology, will take part in the 7th Annual Rural Health Conference scheduled for Keystone Resort, October 23 & 24, 1981.

Weed, originator of the Problem-oriented Medical Record, will be the conference keynote speaker on the first day of the conference which this year, under the title of "The Economics of Survival," will offer a variety of Continuing Medical Education courses for physicians.

For the past 10 years Weed has been involved in the development of various medical information systems for use by physicians in their practices. He will participate as a panel member in the CME course titled: "Computers: How to Choose One and Use One." He will be joined by computer consultants and other medical information systems experts.

The CME course on computers will cover the use of the computer in medical practice to improve patient care and practice management,

what physicians should know about hardware, software and terminology, and will examine several computer systems including: PROMIS, COSTAR, FMIS, and the desktop models—Apple, Radio Shack, Rexxon and Durango, and Hospital Based Systems.

This is the first time in several years that CME courses have been offered to physicians at the rural health conference, according to conference organizers. Another CME course available is "The Rural Health Physician and the Rural Hospital: Survival of the Fittest?" The course will be of particular importance to physicians and administrators since the hospital and the physician in rural areas depend on one another for economic survival. The course will review ways in which the hospital and the physician can assist one another over the next few curricular years, and offer discussion of the future of rural hospitals in Colorado.

The third CME course, "Emergency Treatment of Burns," will feature a presentation by the University of Colorado Health Sciences Center Burn Control Center on burn management in small hospitals, and

rural physicians (both panel members and those participating in the course) will present actual case studies.

Each session has been accredited for 3 hours of CME by St. Mary's Hospital and Medical Center, Grand Junction.

Noted economist Kenneth Boulding of the University of Colorado will also be a keynote speaker at the conference. He is immediate past president of the American Association for the Advancement of Science, has taught at several foreign universities, and is the author of more than 30 books.

Registration fee for the conference is \$35 which includes two meals (dinner on October 23 and lunch on October 24). Conference registrants attending the CME sessions will be charged \$25 for each course, while those not registered for the conference will pay \$40 per session.

Further information concerning the conference or the CME courses may be obtained by contacting Joyce Kriewald, R.N., Office of Rural Health, Room 121, State Capitol Building, Denver, Colorado 80203, or by calling (303) 866-4669.

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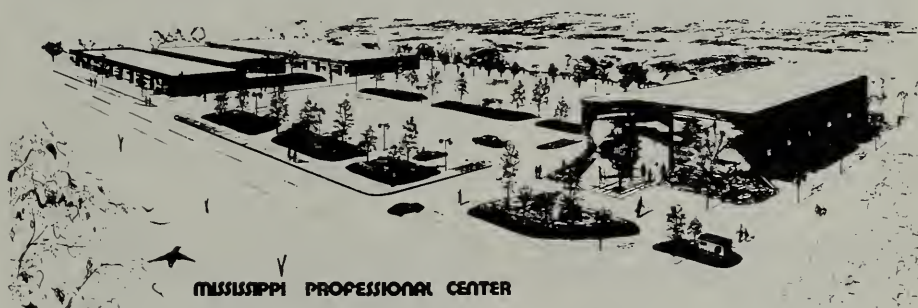
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Drug Therapy: Questions & Answers

Christopher S. Conner, Pharm.D., Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; Dennis R. Sawyer, Pharm.D., Associate Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; Earl Sutherland, M.D., Ph.D., Medical Director, Rocky Mountain Drug Consultation Center, Attending Physician, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center.

PHENOTHIAZINE-INDUCED ARTHRITIS

Request:

A 24-year-old male has received ProlixinR for a period of 3 years and now presents with acute polyarthritis. Has ProlixinR been associated with the development of arthritis?

Response:

A complete review of the literature revealed several cases of muscle cramps and the appearance of miscellaneous aches and pains during prolonged therapy with fluphenazine (ProlixinR) (Keskiner et al, 1969; Rifkin et al, 1971; Bucci, 1968), however, no cases of definite arthritis have ever been associated with fluphenazine or other phenothiazines. In the above mentioned cases, the symptoms may have been associated with development of extrapyramidal-like symptoms.

There have been several cases of systemic lupus erythematosus (SLE) associated with phenothiazine therapy, particularly chlorpromazine (Ananth & Minn, 1973; Dubois et al, 1972; Fabius & Gaulhofer, 1971). In addition, Berglund et al (1970) have reported a significant increase in positive tests for antinuclear factor in patients receiving chlorpromazine as compared to controls. In virtually all cases of SLE with phenothiazines, initial symptoms included joint pains, joint stiffness and/or splenomegaly. The onset of SLE in patients receiving phenothiazines has occurred within one month to 17 months, and symptoms improved upon withdrawal of the phenothiazine in all cases.

To our knowledge, there are no cases of SLE development during fluphenazine (ProlixinR) therapy. Personal communication with the manufacturer of ProlixinR (Squibb Laboratories) also revealed no unpublished cases.

Ananth & Minn (1973) described a case of SLE in a 56 year old female following therapy with chlorpromazine for psychosis in doses of 1600 mg daily over a period of 1 month. The patient was noted to bruise easily and developed joint pain. LE cell prep and antinuclear antibodies were positive, but rheumatoid factor was negative. Upon discontinuing chlorpromazine, improvement in joint pain occurred rapidly with normalization of laboratory findings.

Dubois et al (1972) reported the occurrence of SLE in a 38 year old male following chlorpromazine 400 mg daily over a period of 17 months. After the first 13 months of therapy, the patient developed polyarthritis in the proximal interphalangeal joints, elbows and knees with morning stiffness. The patient was febrile on occasion and noticed increased sensitivity to sunlight. Upon hospital admission 5 months later, the patient was depressed and withdrawn. At this time, the patient exhibited diffuse puffiness of the fingers and slight thickening of the proximal interphalangeal joints secondary to soft tissue swelling. Laboratory data revealed leukopenia, increased SED rate, increased IgM levels and positive LE cell tests and antinuclear antibodies. SGOT was also elevated. Chlorpromazine was discontinued

and the patient improved within a period of two weeks. Disappearance of LE cells and antinuclear antibodies occurred within two months following drug withdrawal. This patient was rechallenged with chlorpromazine and developed identical symptoms.

Other phenothiazines associated with SLE are perphenazine (TrilafonR), prometazine, thioridazine (MellarilR), preazine and methotrimeprazine (LevopromeR) (Fabius & Gaulhofer, 1971).

Conclusion:

Phenothiazines have been associated with the occurrence of polyarthritis secondary to the development of systemic lupus erythematosus, albeit rarely. In at least one case (Dubois et al, 1972) symptoms recurred upon challenge with the drug. Although no cases of SLE have been associated with fluphenazine specifically, it should be considered a possible etiologic factor in the development of this patient's symptoms. Withdrawal of the ProlixinR would rule out a drug-induced SLE. Administration of haloperidol (HaldolR) could be instituted for psychotic symptomatology, as this drug has not been associated with the development of SLE.

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Christopher S. Conner,
Pharm.D. Director,
Rocky Mountain Drug Consultation
Center

Use of Steroids in the Treatment of Myocardial Infarction

Request:

Do corticosteroids have any place in the treatment of acute myocardial infarction?

Response:

The use of steroids in reducing infarction and mortality is controversial. Many authors report a beneficial effect with steroids (Barzilai et al, 1972; Morrison et al, 1976; Vyden et al, 1974). However, others fail to support this belief and some have shown impaired healing of infarction and an increase in ventricular arrhythmias with their use (Roberts et al, 1976; De Mello et al, 1975; Peters, 1978).

The mechanism of action of steroids in myocardial infarctions is debatable. There is some evidence postulating the ability of steroids to stabilize membranes and decrease the liberation of lysosome that can damage cellular structures (Spath et al, 1974; Vyden, 1974; Hoffstein et al, 1976). Another possibility is decreased peripheral vascular resistance with steroids, resulting in increased oxygenation in ischemic tissues (Dietzman et al, 1970).

Peters (1978) conducted a study evaluating methylprednisolone's effect on myocardial infarctions (MI). The first part consisted of a randomized, open study where 9 patients received two IV doses of methylprednisolone (15 mg/kg) within 7-17 hours after onset of symptoms, and 10 controls did not. The second part was a double-blind trial in which 5 patients received 2 IV doses of 30 mg/kg methylprednisone 7-10 hours after onset of symptoms and 5 received placebo. Infarction size was determined by CPK levels.

There appeared no difference between control or treated groups in size of infarction, heart rate or blood pressure.

Morrison et al (1974), however, found a significant decrease in infarction and mortality with 30 mg/kg of methylprednisolone for one or two doses.

Conclusion:

The use of steroids in MI is controversial. Studies have varied due to a large number of factors: clinical state of the patients, dosage, initial administration of the drug in relation to onset of symptoms, duration of therapy and different methods of determining size of infarction. The ability of steroids to alter the infarction progress is questionable.

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USE OF GULCAGON IN ACUTE PANCREATITIS

Request:

I have heard that glucagon may be beneficial in the treatment of acute pancreatitis. Is there any data to support this suggestion?

Response:

Glucagon, despite its known suppressive action on the secretions of pancreatic enzymes and gastric acid, does not appear to offer any beneficial effects on the clinical course or outcome of acute pancreatitis (Debas et al, 1980).

Olazabal & Fuller (1978) evaluated the efficacy of glucagon on alcohol related pancreatitis in a double-blind, randomized study. Twenty-six patients with pancreatitis due to alcohol ingestion were given glucagon or placebo in addition to intravenous fluids, nasogastric suction and meperidine. There were no significant differences demonstrating that glucagon in combination with standard therapy was more efficacious than standard therapy alone.

The effects of glucagon were evaluated in another placebo-controlled, double-blind study in 22 patients suffering from acute pancreatitis (Kronberg et al, 1980). In this study, glucagon had no effect on the mortality or clinical course of acute severe pancreatitis. A randomized double-blind study conducted by Debas et al (1980) also demonstrated no beneficial effects of glucagon in acute pancreatitis, contrary to theoretical expectations.

(Continued on next page.)

Major Issues Facing Colorado Physicians

Kenneth A. Platt, MD, Medical Director, Colorado Foundation for Medical Care



Kenneth A. Platt, MD, Medical Director, Colorado Foundation for Medical Care.

(Continued from previous page.)

Conclusions:

Glucagon has no beneficial effect on the clinical picture or out come of acute pancreatitis, irrespective of the severity or etiology.

References:

Debas HT et al. Glucagon Therapy in Acute Pancreatitis: Prospective Randomized Double-Blind Study. *Can J Surg* 1980;23:578-80.

Kronberg O et al. A randomized Double-Blind Trial of Glucagon in Treatment of First Attack of Severe Acute Pancreatitis Without Associated Biliary Disease. *Am J Gastroenterol* 1980;73:423-5.

Olazabal A, Fuller R. Failure of Glucagon in the Treatment of Alcoholic Pancreatitis. *Gastroenterology* 1978;74:489-91.

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There are several issues facing Colorado physicians at this time. They include:

- the future of the PSRO Program and the continued involvement of the Colorado Foundation for Medical Care in the PSRO movement, if indeed, the program continues,
- the development of a new movement known as "Preferred Provider Organizations" and their implications for the practicing physician,
- the decline of the physician's fee-for-service pricing ability,
- the expansion of hospital outpatient services which will be in direct competition with the private practicing physician,
- a future role for the Colorado Foundation for Medical Care.

The Future of PSRO At a recent meeting with physicians from all over the United States on PSRO, what has happened where the PSROs have been defunded was examined and the potential prospects for the program for next year and for years in the future was discussed.

Forty PSROs have been notified their contracts will not be renewed. The states and areas in which the PSRO has been defunded have been told they have 90 days to come up with a plan for review in place of PSRO review. As an example of what is taking the place of PSRO review, California has developed what is known as the TARS Program. The TARS Program (Treatment Authorization Review) is run by the State Health Department and is essentially a prior authorization treatment program. The State has a bank of physicians who review all medical and surgical admissions to

the hospital. The request for authorization occurs after the fact for emergency admissions and procedures and prior to the fact if it's non-emergency. In other words, the TARS Program is a prior authorization program for state commitment of funds to the treatment of a particular condition or patient or subsequent authorization for an emergency admission.

The physicians have been exempt from prior authorization under the PSRO Program, and pre-authorization review is, therefore, a new experience for them. Some of the physicians are finding it a little disconcerting; others are a little unhappy with the paperwork. However, the program is in its early implementation stage so it is difficult to accurately gauge physician reaction at this time.

Generally speaking, pre-authorization review would appear to be the wave of the future. Across the country, where PSROs have been defunded, the State Health Departments are "picking up the ball" and moving into prior authorization programs with retrospective review of emergency admissions and procedures accompanied by retroactive denial of payment. Prospective denial occurs when the physicians hired by the State feel there is no medical necessity for an admission.

Another area of concern arising out of the California program relates to patients who have a pending MediCal number, but haven't received it yet, and who go into the hospital.

For patients with pending MediCal numbers, the state is not notified prior to admission because eligibili-

ty has not yet been determined. The patients are treated in the hospital, sent home and two weeks later, the patient receives a MediCal number. All because the case did not go through the TARS Program.

What is the future of the PSRO Program? The question needs to be addressed from two perspectives. What is the future of the program and what is Colorado's future? Insofar as the future of the program itself, the attitudes coming from the House of Representatives are in the direction of abolishment of the program at the end of fiscal year 1983. On the Senate side, the attitude appears to be against repeal of the law and in favor of restructuring the system. The Senate proposal would provide for a consolidation of multiple PSROs so that we would end up with between 50 and 60 PSROs across the country, most of which would be statewide. This would enable existing PSROs to fill the gaps where the other PSROs are defunded. Thus, the two Houses of Congress are split on the issue. PSROs are currently operating on the assumption there will be one more contract year after this one which will be October, 1982 through October, 1983, after which the program will cease to be.

If PSRO funds are cut further for fiscal year 1982 to 1983, and 40 more PSROs are defunded, the question is: will the Colorado PSRO survive that second round of cuts? This year the Colorado PSRO was rated in the top 26 out of 180 PSROs for effectiveness. There are now 140 PSROs left. I presume that if another 40 PSROs are dropped, the Colorado PSRO will remain in the top sixty and probably survive another year.

The major issue confronting Colorado physicians at this time is to determine whether they will function under the PSRO program as long as the program exists and either the Administration's program is clarified or until such time the Foundation and/or whatever organization exists can pick up enough private contracts to maintain itself. The chances are that Congress will not repeal the provision for PSRO, but instead develop a vaguely worded funding clause which will allow them to coast into the next year

before finally deciding whether to totally defund PSRO in October of 1983. This will occur because there is a great deal of behind the scenes concern about what is happening to medical care costs. In California, the medical and health care costs are starting to escalate. They are starting to escalate because utilization is escalating in California as it is all across the country. This is not necessarily related directly to removal of the PSRO program. No one really understands why this is occurring. But the fact remains, that all over the country the utilization of the system has been steadily increasing this year and consequently the costs are becoming horrendous. Blue Cross is in trouble and the federal programs are bulging. From Congress' perspective, they see a dramatic increase in utilization and they recognize that the only utilization control they have is the PSRO program. Therefore, I think you will see no repeal of the PSRO law but will instead see a vaguely worded funding clause which will give Congress a loophole in case they need it.

The Development of Preferred Provider Organizations (PPOs)

There is another development that is going to hit the medical community fairly quickly now, and it has already started in the Denver area. Blue Cross is coming in with a 27 to 56 per cent rate increase and all of the insurers are looking at 25 to 40 per cent across the board rate increases. Consequently, insurers and self insured groups are beginning to take a hard look at what they can do from a business viewpoint to control costs. IBM is prepared to move across the board in HMOs, closed panel or staff models, or if they are not available, HMO-IPAs. There is a tremendous movement across the country from big corporations to go self insured rather than to contract with insurance companies. This means a great deal of business is going to fall off as far as insurers are concerned.

Another approach they are looking at, in addition to the HMO-IPA movement, is the so-called "PPO movement." The acronym "PPO" stands for Preferred Provider Organization. Preferred Provider Organizations are appearing on the Denver scene already. There are

two major PPOs so far. One is Martin Segal through the Union Trusts, and the other is Far West Administrators, which is putting together a PPO group. A Preferred Provider Organization is essentially an HMO "without walls" and without federal qualifications. What you do is sign as a participating physician or organization with the Preferred Provider Organization and agree to accept a previously set fee, a previously designated institution, and agree to accept binding peer review with no recourse unless it is spelled out in the contract. In other words, the contract specifies a flat fee. The provider agrees to it, that is what he receives and he agrees not to bill the patient for the remainder. The PPO concept is similar to the original Colorado Foundation for Medical Care concept, where the physician signed up with the Foundation and agreed to accept payment in accordance with a negotiated fee structure. Signing up with PPOs will be almost like signing up with multiple Foundation programs, as originally envisioned.

Nationally, Paul Elwood, out of Inter-Study, the father of the HMO, has "jumped the bandwagon." He feels that PPOs are a viable alternative to the current system and he is promoting them across the country. It looks as if PPOs will be successful. For example, response to the Far West Administrators program has been tremendous. The first day they announced the plan in one area, they had companies representing 120,000 people standing in line to sign up. A week later, they opened up another office, and had 60,000 people sign up on the first day. What we are seeing is the response of business to spiraling costs. They are willing to buy or at least try any program that has some ceiling on costs and some peer review.

Therefore, Preferred Provider Organizations may be very much a fact in your future. As a physician, you may find yourself signed up with a half dozen different programs such as Blue Cross-Blue Shield, Compicare, Sloans Lake Medical Group and Far West Administrators. Each one may have a different ceiling and each may have a different type of peer review. From the Foundation's

viewpoint, and from your viewpoint, there are two things that I think are key. First of all, PPOs are in essence, a cap on fees and secondly, peer review is part of it. In my opinion I do not think any of these organizations really know what peer review is all about. What you may see as more of these organizations are established and more people become committed to them, is that they will start looking around for someone to do their peer review. This may, in turn, come back to you at the Foundation level, so Preferred Provider Organizations are very much "a new sparkle" in the system. Some people claim they are the way of the future. You are going to be confronted with them if you haven't already been, and indeed they may appeal to people who don't want to become involved in a structured HMO with federal qualifications.

Increasing Limitations on Physicians Pricing Abilities Another major factor in the system is the large hospital chain corporation. You are going to see corporations such as the Catholic Hospital Association, the Lutheran Hospital and Humana Corporation start to build and promote HMOs linked to their hospital chains across the country. The Catholic Hospital Association is getting ready to make their decision and wants to apply to the American Association of Foundations for Medical Care (AAFMC) for membership. The Humana corporation already has an application into the AAFMC to bring its HMO into the fold. Prudential and all of the big insurance companies are starting to move into the HMO field and the big hospital chains will be promoting HMOs. This will result in additional fractionalization of the system and you can expect to see tremendous fragmentations before long as a result of all of these things.

In many areas of the country, the physicians have already lost their pricing ability. You can anticipate that in the future physicians will increasingly lose their fee for service pricing ability and will lose many of their personal freedoms. It has been estimated by some authorities that by 1985 forty per cent of your practice will be covered by Medicare or

Medicaid, another forty per cent by PPOs or HMOs or other types of structured systems and that your ability to price independently will be limited to 20 per cent of your practice, which literally means you will be captive.

In other places in the country, Foundations for Medical Care are responding to the situation. In Minneapolis, the Foundations went out and signed up 120,000 people for their Foundation/PSRO. The reason they did this is that Minneapolis doctors were confronted with six different HMO-IPAs. The competition was fierce and the doctors said: "We will try anything that will give us some lee-way outside of these HMOs." 120,000 signed up and the physicians who participated agreed to pre-admission authorization and to pre-procedure review. It would appear that physicians are willing to accept the things they are complaining most about such as pre-admission review when the pressures become sufficiently intense.

The Competition Between Hospitals and the Doctors In the future, one of your worst enemies is going to be your hospitals. Under the pressures that these competition movements are generating, with the concerns about escalating costs, and the de-emphasis on in-patient care, the hospitals are going to become competitive not only with other hospitals but with the primary care physician as well. Hospitals will be moving more and more into the outreach system including independent, free-standing or closely associated ambulatory surgical centers and 24 hours a day emergency medical centers directly linked to the hospitals. Hospitals will be providing primary care, in the sense of screening or triage care, right next door to you. If you don't think this is going to happen, look at the contracts hospitals are beginning to sign with people in outlying communities—mountain communities, suburban communities and Eastern slope communities. Look at the proposals before the planning groups as far as free standing and associated ambulatory surgical centers are concerned.

You are going to see the hospital

sitting out there in direct competition with the private physician. The private physician is, therefore, facing some very ominous threats to his continued existence. Some people predict that by 1990 the physician will be a salaried employee of the hospital or will be so structured into the system that he will essentially have no liberties. In other words, he will be told where he will practice, what he will practice, and what he will get paid for.

A Role for The Colorado Foundation for Medical Care I think the success of the Colorado Foundation For Medical Care is going to be absolutely incumbent upon the Medical Society, by whatever socioeconomic committee or arm it has, to stay abreast of these movements and to keep the physicians informed. I would strongly suggest the Colorado Foundation for Medical Care, if the Medical Society decides to maintain it and solidify it, accept this function as one of its primary goals. It is very difficult for the practicing physician to even be aware of what is going on—it is happening so fast—let alone know how to respond to it. Issues that will need to be brought to physicians' attention are questions like: "What are dangers of signing up with HMOs, PPOs or other medical practice groups? What are the implications for my practice when my hospital builds an ambulatory surgical center, or a primary care facility down the street from my office?" Doctors will have to have someone monitoring the situation and advising them of the implications of each new development for the future of medical practice. I believe the Colorado Foundation for Medical Care has the capacity to do this and indeed this ought to be one of its primary goals as long as it continues to exist.

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Cyclosporin A: A New Immunosuppressive Agent

The metabolite of a fungus named *Trichoderma polysporum* Rifai is being investigated by prominent transplantation specialists who hope it can be used as a new immunosuppressive agent. Preliminary clinical trials reported at the Eighth International Congress of the Transplantation Society, show the effectiveness of the drug, cyclosporin A (CsA), in overcoming rejection of transplanted hearts, lungs, kidneys, livers, and bone marrow. Unfortunately, other reported effects include disturbing symptoms that range from facial hirsutism and gum hyperplasia to kidney toxicity and malignant lymphoma. These unwanted effects, and the mechanism by which CsA alters the immune response to graft antigens, will be studied in controlled clinical trials scheduled to begin in the next few months. Also, investigators will try to determine if CsA is superior to conventional steroids and cytotoxic drugs, or most effective when combined with reduced dosages of these drugs to eliminate the grave problems caused by high doses of long-term steroid therapy.

In contrast to steroids, CsA does not inhibit the entire immune system. Rather, it slows the cloning of T-lymphocytes and spares lymphocytes that are not activated by transplanted tissue antigens. Researchers speculate that CsA, which is highly fat soluble, has an affinity for lipid receptors on target lymphocyte membranes, and that it directly induces T-lymphocyte suppressor cells. Possibly, by interfering with the proliferation of a subset of T-cells, it allows the simultaneous development of a suppressor cell system. Very few facts about the

pharmacology of CsA have been established since its isolation 10 years ago.

Cyclosporin A was identified in 1970 at Sandoz Pharmaceuticals in Hardanger, Norway, after a routine screening of soil for new antimicrobial agents. Researchers at Sandoz noted that, while the chemical had no antibacterial and minimal antifungal properties, it exhibited important immunosuppressive action. The researchers characterized the drug as a cyclic peptide, having 11 amino acids in a closed chain, the chemical formula $C_{62}H_{111}N_{11}O_{12}$ and the molecular weight 1201.63. Its structure exhibits unusual design in that one of the 11 amino acids, an unsaturated C-9 amino acid, is not known to be duplicated elsewhere in nature, and the alanine branch exists in dextro configuration rather than the levorotation characterizing most other amino acids.

To encourage investigation of this unusual chemical, Sandoz made it available in 1972 to 10 surgeons in Britain, France, Canada, and the United States, including Dr. Thomas Starzl who conducted research trials with 38 kidney-graft and nine liver-graft recipients at the University of Colorado Health Sciences Center. Favorable results were reported by Starzl: a 5.6 per cent mortality rate, 2 donor organs rejected, and 1 lost due to ureteral necrosis; but 32 kidney transplant patients were freed from dialysis and 8 of the 9 liver transplant patients were alive when the report was published. These results differed in two ways from data published by the first doctor to use CsA in patient therapy, Dr. Roy Y. Calne of Addenbrooke's Hospital in

Cambridge, England. First, lymphomas did not occur in Starzl's trials, and second, gradual deterioration of kidney function, present in both studies, was improved in Starzl's trials after administration of steroids, indicating that dysfunction is due to delayed rejection rather than drug toxicity as Dr. Calne suspected. In his report, Dr. Starzl recommended combined therapy with CsA and low-dose steroids.¹

Another significant application of CsA is suggested by research with leukemia patients receiving bone marrow transplants. In these patients, donor white cells can attack the recipient's system with fatal results (graft-versus-host disease). Trials at the Royal Marsden Hospital in Durrey, England, have demonstrated a 69 per cent survival rate for patients with well-matched bone marrow transplants, after long-term CsA therapy, and eight patients with mis-matched donor grafts had a 50 per cent mortality rate on CsA.⁴ Relative success in treating these severely ill patients may indicate that CsA has anti-leukemic action as well as immunosuppressive effects.

Most researchers, even those reporting less success and higher incidence of side effects, advocate more controlled studies for CsA. Clinical research had been stimulated by the perfection at Sandoz Pharmaceuticals of a new radioimmune assay for the detection of blood levels of cyclosporin A, a technique that will enhance control over the administration of the drug in dosage studies. Also, Sandoz recently arranged for controlled trials to be conducted with 100 patients in five clinics in Canada and five in Great Britain, Germany, Austria, and Switzerland. Other controlled studies are planned by Dr. Norman Shumway at Stanford University where heart transplant surgery continues. Dr. Shumway is optimistic that combined low-dose steroid and cyclosporin A therapy will make heart transplantation as successful as cadaver-kidney transplants are now.

What to Do About The Future of Medical Practice:

excerpts from address by Frederick A. Lewis, Jr., MD,
the new CMS President,
before the Annual Session of the House of Delegates.

I want to thank you all for the privilege of being able to address you in the role of President of the Colorado Medical Society. It is an honor and a responsibility which I take seriously and will do my best to fulfill.

These are, indeed, provocative and challenging times for the medical profession but, with your help, we can make this next year a constructive year.

I was talking to Ken Platt about 15 months ago—shortly after it became common knowledge that I was going to be nominated as President-

Elect. His response to the news was to say "I guess that makes sense; you have certainly been around long enough." A response like that didn't do great things for my ego, but after recovering from the mid-life depression which Ken's remark precipitated, I realized, sadly, that he was right. I have been "around" in various roles for a long time. Obviously, there are many physicians who have been active in the CMS longer than I, but I suspect there are a fair number who do not truly understand what has happened to the CMS over the past five years.

The just-completed Annual Meeting of the House of Delegates was the culmination of an effort which began in 1976 to reorganize the Colorado Medical Society. A number of significant changes have been made. The new Constitution, Bylaws and Standing Rules which were ratified at the Annual Meeting has made CMS much better able (than we were in 1976) to meet the challenges which lie ahead. And the reorganization of CMS has occurred just in time—for medicine is moving into a difficult and challenging era.

Our country is currently going through a peaceful revolution. Most of the basic governmental philosophies and values which have prevailed over the past 50 years have been challenged and are in the midst of change....change which is going to have a profound impact on our country, in general, including the practice of medicine. Thoughtful and knowledgeable physicians have already begun to squirm on the horns of the dilemma.

Most doctors are politically conservative. I would guess that most of us are in favor of tax cuts, block grants, budget cuts in social welfare



programs, deregulation and a return of the programmatic responsibility to the State for a variety of federally administered programs. However, when faced with the realization that this overall philosophy also applies to medical programs, we have to stop and reflect as to the potential impact on physicians and their patients. The federal government pays about 43 per cent of the nation's health care bill, which obviously makes it the world's largest third party payer. Medicare and Medicaid will cost over \$60 billion this year. The Reagan Administration is obviously going to try to cut this figure as much as it possibly can. In an effort to come up with a balanced budget this is certainly what most of us would do if we were President.

Similarly, at the State level, most doctors are probably in favor of the Kadlec Amendment which limits the annual growth of the State budget to 7 per cent. However, to be in favor of this spending limitation and, at the same time, to expect the State to markedly increase expenditures for Medicaid or to fund a medically indigent program may be unrealistic. I suggest we recognize that.

In addition, the Reagan Administration is in an extremely awkward position, vis-a-vis medicine and the health care delivery system. The current buzz-word is competition, but unfortunately you cannot have competition in health care without increased regulation. Those of you who have read the Gephardt-Stockton Health Care Bill must have been as surprised as I to find the number of new bureaucratic structures, the number of rules, regulations, and red tape which were created....because, in order to insure competition in the health care arena, the federal government has to change the tax laws and, in addition, has to regulate business, labor, and the health insurance industry—not to mention doctors and hospitals. Therefore, it is going to be virtually impossible to endorse competition and deregulation at the same time.

In any event, all of these forces will gradually result in substantial changes in the health care delivery system and increasing infringements on our right to practice medicine in the manner we feel is best for our in-

dividual patients.

One suspects that the major ingredient of health care, which will get lost in the shuffle, is quality of care. If you look at all of the organized groups in the health care arena, you come to the conclusion that the only one with a primary investment in quality of care is the medical profession. Consumers are not really interested in quality until they become patients and, at that point, they are no longer organized.

All of this may sound grim, but to me it certainly implies that we have our work cut out for us over the coming decade. However, there are some things which we can do, locally and nationally, in an effort to stem the tide:

First, the medical profession has to remain unified, so we must increase our membership at both the state and the AMA levels. The current AMA membership in Colorado is about 40 per cent and one of my goals, and I hope yours, is to increase this figure significantly. Another 65 AMA members will give us a third AMA delegate. The AMA is the only organization we have which represents all doctors at the national level—which is where most of the decisions crucial to medicine will be made over the next few years. By necessity, the AMA will have to carry the physician's message if it is to be heard in Congress and by the new Administration.

Second, I would like to see much stronger support of COMPAC and, by extension, AMPAC. Anyone involved in politics will tell you that the only way to achieve your goals in the political arena is to help elect legislators, be they democrat or republican, who are sympathetic to your cause. In the past, the medical profession, as a whole, could afford a cavalier, somewhat disdainful approach to the political process. We can no longer afford this luxury. The newly elected chairman of COMPAC, Dr. Bob Safford, is going to do his best to reorganize and revitalize this organization so that it is more appealing and meaningful to Colorado doctors. I would urge that the Medical Society give COMPAC its total support.

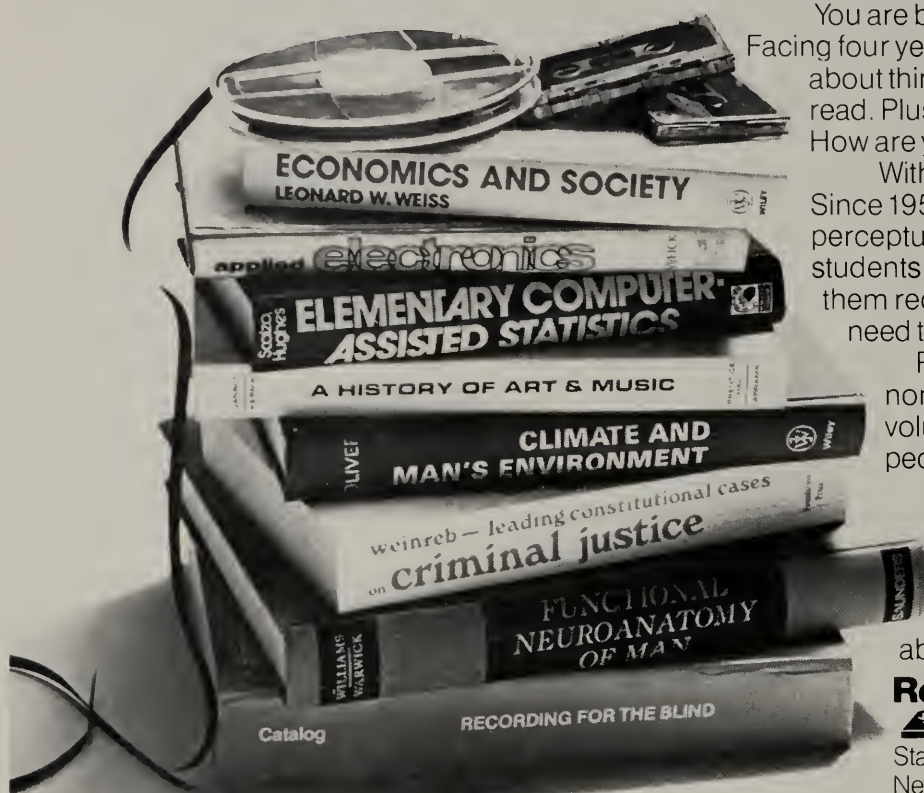
Third, at the recent President's Planning Session, the CMS leader-

ship from around the state met to consider programs and priorities for the coming year. A total of 17 issues were considered and have been combined into 7 prioritized programs for 1981-82. They are designed to address the issues which have been previously outlined.

Finally, I would urge your support of the Colorado Foundation for Medical Care. Although there is some difference of opinion, it is my impression that most physicians do not support a federally mandated peer review system and the House of Delegates, at its March, 1981, meeting, voted to support the repeal of the PSRO law. PL 92-63 was not repealed and continues to be funded, presumably until the new pro-competition legislation is enacted. However, all of the political forces which I have outlined earlier will almost certainly unite in pressure for increased peer review. Actually, most physicians are in favor of local peer review and, to my knowledge, all physicians prefer review by their peers over review by unknown bureaucratic clerks. If we, as a state medical society, have any hope of establishing an effective and respected statewide or local peer review program, we are going to have to be in a position to use the resources of the Foundation as a springboard. The Foundation has the standards, the data, the experience and the staff. I would urge all of you to look squarely at the situation in which the medical profession finds itself; look at the dangers and uncertainties which lie ahead....then use the assets and potential which reside in the Colorado Foundation for Medical Care.

With this outline of past accomplishments and future challenges, I ask that we all unite behind the decisions which have been made by the just-concluded meeting of the House of Delegates. By doing so, organized medicine in Colorado will be in a position to influence its own destiny.

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October

1 Neuropsychiatric Grand Rounds: 1-3 p.m. APA approved courses for Category I credit, developed by Colorado State Hospital to examine the relationship of neurological and psychiatric disorders. Colorado State Hospital, Pueblo. Conference Room A. Contact: James H. Scully, M.D., 1600 W. 24th St., Pueblo, Colorado 81003. Tele: (303) 534-1170.

2-3 "Sexuality In '81: Issues In Counselling & Education"—9:00 a.m. to 5:00 p.m. both days.—Holiday Inn - Airport, 970 Dixon Rd. Rexdale, Ontario M9W 1S9. Enquiries: Conference & Seminar Services, 205 Humber College Boulevard, Rexdale, Ontario M9W 5L7. Tele: (416) 675-7420.

5 What You Should Know About Anticoagulants—Burlington, Colorado. Contact: Martin Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, Colorado 80202. (2 hours of AMA Category 1 Credit; 2 prescribed hours of AAFP Credit).

5-9 Clinical Management and Control of Tuberculosis, at Denver; sponsored by National Jewish Hospital and Research Center/National Asthma Center, Denver. Course Director: Thomas Moulding, M.D. 40 hours of AMA Category I credit, AAFP credit pending; registration fee \$300.00, \$150.00 for physicians in training. Contact: Ms. Shirley Marls, NJH/NAC, 3800 East Colfax Ave., Denver, Colorado 80206. Tele: (303) 388-4461.

7-10 Western Occupational Health Conference's 25th Silver Anniversary Session for 1981—"Regulation, Friend or Foe." Held at Doubletree Inn, Monterey, California. Contact: Joe Donovan, 433 Palmer Avenue, Aptos, California 95003. (408) 688-9667. C.E. credit is approved for physicians and nurses; other credit approvals are pending. Pre-registration fees vary from \$50 to \$65; student fees are \$25. Special workshop fees range from \$20 to \$35.

9 Hypertension Symposium - Red Lion Motor Inn, 2001 Point West Way, Sacramento, California. Credit: 7 hours Category I for physicians; accreditation applied for from American Academy of F.P. & University Ext. for registered nurses. Contact: Ardi Neiswonger, Publications Representative, Office of Continuing Medical Education, School of Medicine, University of California, Davis, Tele: (916) 752-0328.

9-10 Sexually Transmitted Diseases - The Hotel Vancouver, Vancouver, BC, Canada. Contact: University of Washington School

of Medicine, Division of CME, E-303 HSB, SC-50, Seattle, Washington 98195.

10-11 The Charley Smyth Symposium on Arthritic & Rheumatoid Condition of the Upper Extremity: The Fairmont Hotel. Contact: John A. Boxwick, Jr., M.D., 4200 E 9th Ave, Box C-309, Denver, CO. Tele: (303) 394-8718. (14 hours of AMA Category I credit).

12-13 South Dakota Perinatal Association Sixth Annual Perinatal Conference—Holiday Inn, Spearfish, South Dakota. 9.6 hours credit applied for. Guest speakers include: Preston Dilts, M.D.; John Grossman, M.D.; George McCracken, M.D.; Lu-Ann Papile, M.D. Contact: Margo Varcoe, R.N., S.D.P.A., 1100 S. Euclid, Sioux Falls, South Dakota 57105. Tele: (605) 339-6578.

12-15 Sixth Annual San Diego Radiology Course San Diego California. Contact: Mary J. Ryals, Director of Postgraduate Education, San Diego Radiology Research & Education Foundation, Suite 101, 10855 Sorrento Valley Road, San Diego, California 92121. Tele: (714) 452-4722.

17 Practical Applications of Allergy for Primary Care Physicians at NIH, Bethesda. 6 hours of AMA Category I credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital, 3800 E. Colfax Ave., Denver, Colorado 80206. Tele: (303) 388-4461.

18-22 Hospital Medical Staff Conferences & Hospital Trustee Forums -Monterey, California. Contact: Estes Park Institute, P.O. Box 400, Englewood, Colorado 80151. (303) 761-7709.

20 SIDS - Sudden Infant Death Syndrome - Sponsored by the SIDS Counseling and Information Center, The Children's Hospital, Denver. Held at Sheraton Inn, Airport, Denver. AMA Category I credit available. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, Colorado 80218. Tele: (303) 861-6949.

20-25 General Medicine: Hilton Head Inn, Hilton Head Island, South Carolina. Registration Tuesday, October 20th, 4:00 to 6:00 p.m. Contact: Beth Israel Hospital, Conference Program, P.O. Box 11366, Denver, Colorado 80211. Denver Metro Area: (303) 629-5333; Outside Colorado: (800) 525-5810. 20 hours credit.

21 Hypertension Symposium - Red Lion Motor Inn 2001 Point West Way, Sacramento, California. Credit: 7 hours Category I for physicians. Contact: Ardi Neiswonger, Publications Representative, Office of Continuing Medical Education, School of Medicine, University of California, Davis. (916) 752-0328.

22 "Developing Your Own Support System"—Seminar on Multiple Sclerosis—held at Beth Israel Hospital and Geriatric Center, Denver. Contact: Beth Israel Education Center, 1601 Lowell Blvd., Denver, Colorado 80204. Tele: (303) 825-2190, ext. 266 or 457.

22-23-24 The 12 Lead ECG for the Primary Care Physician: Location: Presbyterian Hospital, Albuquerque, New Mexico, sponsored by the New Mexico Heart Institute. Fee: \$150.00 CME Credit: AMA Category I -23 hours. AAFP -23 hours. ACEP - 23 hours. Contact: Barry W. Ramo, M.D. (505) 242-2796.

23-24 Multiple Sclerosis: Research and treatment—Seattle, Washington. Contact: University of Washington School of Medicine, Division of Continuing Medical Education, E-303 HSB, SC-50, Seattle, Washington 98195. Credit: 9.5 In-session hours, .95 CEU Equivalent.

24 The Office Management of Sadness and Its Variations: Brief course in psychotherapy for practicing Physicians. Site: Red Lion Motor Inn, 2001 Point West Way, Sacramento, California. Tuition: \$75.00 Credit: 7 1/4 in Category I for physicians; accreditation applied for under American Academy of Family Physicians and Bureau of Registered Nurses. Contact: Ardi Neiswonger, Publications Representative, Office of Continuing Medical Education, School of Medicine, University of California, Davis. (916) 752-0328.

28 Most Common Errors In Gastroenterology & How to Correct Them—Julesburg, Colorado. Credit, Category I hours & AAFP prescribed credit: two. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, Colorado 80202.

30 Round Robin Conference - at Lamar, Colorado. Sponsored by American Lung Association of Colorado. Contact: Monica Ledesma. Tele: (303) 336-4343.

30-31 5th National Conference on Medical Care and Health Services In Correctional Institutions - at Chicago's Marriot Hotel. Contact: B. Jaye Anno, Director, Department of Correctional Activities, American Medical Association/American Correctional Health Services Association.

November

1-4 Evaluation of Medical Disabilities In the 1980's, with particular emphasis on those disability programs administered by the Social Security Administration. Sponsor: National Association of Disability Examiners (N.A.D.E.);

Host Chapter: Colorado Association of Disability Examiners; Site: Plaza Cosmopolitan Hotel, Denver, Colorado. Contact: Jean Rueschoff, President, Colorado Association of Disability Examiners, P.O. Box 24281 or 2121 S. Onelda, Suite 200, Denver, Colorado 80224. Tele: (303) 758-5539

1-5 88th Annual Convention of the Association of Military Surgeons of the United States. To be held at the Convention Center, San Antonio, Texas. The program will include continuing education offerings for physicians, dentists, nurses and many other disciplines. Contact: Mr. T. A. Glasglow, Chief, Corporate Planning, HQ, Aerospace Medical Division, Brooks Air Force Base, Texas 78235. Tele: (512) 536-3656 or CDR T.G. McMahon, Asst. Exec. Dir., AMSUS, P.O. Box 104, Kensington, Maryland 20795. Tele: (301) 933-2801.

2 "Management Skills for Health Care Supervisors"—Denver, Colorado. Contact: Beth Israel Education Center, 1601 Lowell Blvd., Denver, Colorado. Tele: (303) 825-2190, ext. 266.

3-4 Symposium on Diet and Exercise—Synergism In Health Maintenance: Lake Buena Vista, Florida (Walt Disney World Complex). AMA Category 1 Credit on an hour-for-hour basis towards the physicians' Recognition Award of the AMA. 13 prescribed hours by the American Academy of Family Physicians. Fee: \$60. Contact: Department of Foods & Nutrition, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610. Therese Mondeika, R.D., Dept. of Foods & Nutrition (312) 751-6524.

5 Neuropsychiatric Grand Rounds, 1-3 pm. APA approved course for Category I credit, Developed by Colorado State Hospital to examine the relationship of neurological and psychiatric disorders. Colorado State Hospital, Pueblo, Colorado. Conference Room A. Contact: James H. Scully, M.D., 1600 W. 24th St., Pueblo, Colorado. Tele: (303) 534-1170.

8-15 Update In Clinical Endocrinology & Infertility: Hilton Head Inn, Hilton Head Island, South Carolina. Registration: Sunday, Nov. 8th. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, Colorado 80211. Tele: (303) 629-5333. Toll-free outside Colorado (800) 525-5810.

10-14 "Cancer 1981/2001—An International Colloquium"—Shamrock Hilton Hotel, Houston, Texas. Contact: Lisa Long or Joan Chin at (713) 792-3030. The University of Texas System Cancer Center, M. D. Anderson Hospital & Tumor Institute, Texas Medical Center, 6723 Bertner Avenue, Houston, Texas 77030.

11 Regional Computerized Tomography/Neuroradiology/Ultrasound Conference, Dept. of Radiology, Saint Luke's Hospital, Denver, Colorado, 5:30 pm to 9pm, Aspen Room, RSVP one week in advance. Contact: Suzanne Warner (303) 394-7774 (3 hours AMA Category 1 credit).

14 Modern Drug Therapy of Common Pulmonary Diseases at Medical Education Wing of the V.A. Medical Center, Fresno, California.

6 hours of AMA Category 1 credit; AAFP credit pending. Contact: Kathleen Wolff, Program Representative, c/o Area Health Education Center, 5110 East Clinton Way, Suite 210, Fresno, California 93727. (209) 252-1948.

14 Ambulatory Medicine Symposium—Current Treatment of Common Office Care Problems. Marriott Hotel, I-25 & Hampden Avenue, Denver. Sponsored by the Colorado Permanente Medical Group, P. C. Contact: Joyce Nordstrom (303) 961-3263. Write: 2005 Franklin Street, Denver, Colorado 80205. Credit: 7 hours of AMA Category 1 or AAFP prescribed credit.

15 "Dilemmas With Drugs In Clinical Practice"—Sheraton Universal Hotel, North Hollywood, California. Credit: 6 hours of Category 1 of the Physicians Recognition Award of AMA & the Calif. Medical Assoc. Certificate, and 6 Continuing Education hours. Contact: (213) 825-7257—UCLA Extension, P.O. Box 24901, Los Angeles, CA 90024.

17-20 Region VIII Family Planning Conference - Management and Medical Update. Location: Stouffer's Inn at the Airport, Denver, Colorado. Professional credit available for Physicians (CME - Category I), Nurses (CEUs), and Social Workers. Registration deadline October 25, 1981. Contact: M. Deborah Casselman, Region VIII Training Center, Rocky Mountain Planned Parenthood, 1525 Josephine, Denver, Colorado 80206. Telephone: (303) 321-2471.

20 "Death & Dying"—Beth Israel Hospital & Geriatric Center, Denver, Colorado. Contact: Beth Israel Education Center, 1601 Lowell Blvd., Denver, Colorado 80204. (303) 825-2190.

20 Paul R. Hackett Memorial Pediatric Anesthesia & Merry Simmons Critical Case Symposium, sponsored by the Department of Anesthesiology, the Children's Hospital, Denver, Colorado. Held at Marriott Hotel, Southeast. AMA Category 1 credit available. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, Colorado 80218. Telephone: (303) 861-6949.

Nov 29-Dec 3 Hospital Medical Staff Conference - Clearwater Beach, Florida. Contact: Estes Park Institute, P.O. Box 400, Englewood, Colorado 80151. Telephone: (303) 761-7709.

December

3 Neuropsychiatric Grand Rounds; 1-3 p.m. APA approved course for Category I credit developed by Colorado State Hospital, Pueblo. Contact: James H. Scully, M.D., 1600 West 24th Street, Pueblo. (303) 543-1170. (Note: Subsequent Grand Rounds will be held January 7, 1982, February 4, 1982, March 4, 1982, April 1, 1982 and May 6, 1982).

3-5 The Sports Physical Therapy Section of the American Physical Therapy Association in association with the Medical College of Virginia School of Physical Therapy will present the 2nd Annual Combined Physician-Therapist Conference on **"The Evaluation and Current Treatment of Athletic Injuries: The Lower Extremity Kinetic Chain"** at the Hyatt Regency O'Hare, Chicago, Illinois. Credit: 17 hours AMA Category 1. Contact: Ms. Kathy Johnson, Continuing Medical Education, Box 48, MCV Station, Richmond, Virginia 23298.

4-11 Behavioral Medicine & Primary Care in the 80s - Ilikai Hotel, Honolulu, Hawaii. Sponsored by: Professional Institutes, University of South Carolina School of Medicine. Credits: Approved for 16 hours AMA Category I credit of the Physicians Recognition Award. Approved for 16 prescribed hours by the American Academy of Family Physicians. Contact: Jeri McClain, Administrative Assistant, USC School of Medicine, Office for Academic Affairs, Columbia, South Carolina 29208. Telephone: (803) 777-7470.

9 Regional Computerized Tomography/Neuroradiology/Ultrasound Conference, Department of Radiology, University Hospital, Denver, Colorado 5:30 pm to 9pm, Room #2242. RSVP one week in advance. Contact: Suzanne Warner (303) 394-7774. (3 hours AMA Category I credit) This meeting is sponsored by the Department of Radiology, University Hospital & by the office of Postgraduate Education of the University of Colorado School of Medicine.

10-12 The Management of Patients with Burn Injuries—Brown Palace Hotel. Contact John A. Boswick, Jr., M.D., 4200 E. 9th Avenue, Box C-309, Denver, Colorado 80262. Telephone (303) 394-8718. (18 hours AMA Category I credit).

January

"Clinical Cytopathology for Pathologists -Postgraduate Course"—The 23rd Postgraduate Institute for Pathologists in Clinical Cytopathology is to be given at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, Baltimore, Maryland, March 22, 1982 -April 2, 1982. **Please Note: While the course is not until March, 1982, the deadline for applications is shortly after the first of January, 1982, (before 1/27/82).** Contact: John K. Frost, M. D., 610 Pathology Building, The Johns Hopkins Hospital, Baltimore, Maryland 21205.

3-8 Ninth Annual Symposium on Clinical Echocardiography: Clinical Applications & New Developments in Cardiac Imaging at Snowbird Ski Resort - Snowbird Conference Center, Snowbird Ski Resort, Snowbird, Utah. Contact: American College of Cardiology - Ms. Mary Anne McInerney, Director Extramural Programs Department, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

9-16 Current Clinical & Legal Issues: The Mark, Vail, Colorado. Contact: Beth

Israel Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone (303) 629-5333; toll-free outside Colorado (800) 525-5810.

11-15 **13th Annual Cardiovascular Conference at Snowmass:** Snowmass Resort, Snowmass, Colorado. Contact: Registration Secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014. Telephone: (301) 897-5400.

13-16 **Supercourse VII - A Clinical Course on Critical Pulmonary Care:** Fairmont Hotel, New Orleans, Louisiana. Accredited by the AMA in Category I for the Physicians Recognition Award. Sponsored by the American Lung Association of Louisiana and the American Thoracic Society of Louisiana. Contact: Course Coordinator, American Lung Association of Louisiana, 333 St. Charles Avenue, Suite 500, New Orleans, La. 70130. Telephone: (504) 523-5864.

17-22 **Keystone Summit on Allergy, Immunology and Pulmonology:** Keystone, Colorado. 21 hours of AMA Category I credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital/National Asthma Center, 3800 E. Colfax Avenue, Denver, Colorado 80206. Telephone: (303) 388-4461.

18-21 **Chest Radiology - 1981 & 1982—**San Diego, California. Contact: Mary J. Ryals, Suite 101, 10855 Sorrento Valley Road, San Diego, California 92121. Tele: (714) 452-4722.

21-23 **"Topics in In-Patient Psychiatry"—**held at The Mark, Vail, Colorado. Room deposits must be made by September 20, 1981. Contact: Joanne H. Ritvo, M. D., Program Chairman, Colorado Psychiatric Society, 1555 East Lake Place, Littleton, Colorado 80121.

27 **Health in the Occupational Environment—**Julesberg, Colorado. Number of Colorado Medical Society Category I hours & AAFP prescribed credit: two. Contact: Martin J. Rubinowitz, M. D., The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

27-29 **"Echocardiography: An Introduction Course for the Practicing Physician"—**Beverly Hilton Hotel, Beverly Hills, California. Contact: Ms. Mary Anne McInerney, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

7-12 **Fifth Annual Postgraduate Course New Approaches to Clinical Problems in Internal Medicine—**Snowmass Village, Snowmass, Colorado. Presented by the Department of Medicine, University of Colorado School of Medicine. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone (303) 394-5241.

8-12 **The Denver Postgraduate Institute in Emergency Medicine: Pediatrics, OB-GYN & Surgical Subspecialties.** Contact: Janice Alexander, Denver Postgraduate Institute in Emergency Medicine, Emergency Medical Services, Denver General Hospital, West 8th & Cherokee, Denver, Colorado 80204. Telephone: (303) 893-7034

8-12 **35th Annual Meeting of the Northwestern Medical Association - Scientific/Skl Meeting.** Place: Sun Valley, Idaho. Credit: 10 CME Category I. Contact: Norman Christensen, M. D., Secretary, 2456 Buhne Street, Eureka, California 95501.

11-13 **"Perspectives on New Diagnostic & Therapeutic Techniques in Clinical Cardiology: Exercise Testing Post Myocardial Infarction, Radionuclide Cardiac Imaging, 2-D and 3-D Echocardiography, Coronary Artery Spasm, Calcium Channel Blockers, Coronary Angioplasty, Thrombolytic Therapy, Coronary Surgery"—**Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista, Florida. Contact: Mary Anne McInerney, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

13-20 **OB/GYN at Marriott's Mark Resort, Vail, Colorado (ACOG credit); Psychiatry at Lion Square Lodge, Vail; Geriatric Medicine at The Lodge at Vail.** Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. (303) 629-5333. Toll-free (800) 525-5810

14-19 **Eighth Annual Winter Skin Seminar—**The Given Institute of Pathobiology, Aspen, Colorado. Contact: The Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone: (303) 394-5241

18-20 **"Nuclear Medicine For Physicians and Technologists"—**San Diego, California. Contact: San Diego Radiology Research & Education Foundation, P. O. Box 2305, LaJolla, CA. 92038. Telephone (714) 453-7500, ext. 3711

February

6-13 **Emergency Medicine/Critical Care at** Marriott's Mark Resort, Vail, Colorado. (ACEP credit) 22 credit hours. Urology at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone: (303) 629-5333. Toll-free (800) 525-5810.

Hubert L. Binkley died on August 7, 1981, at his home. He was 70. Dr. Binkley, who lived at 8661 E. Grand Avenue, Denver, was born May 18, 1911, in Kalamazoo, Michigan. He graduated from Denver East High School, Colorado State University and the University of Colorado School of Medicine.

Binkley married H. Louise Mitchell, who died in 1973. Dr. Binkley was a veteran of the U.S. Army Medical Corps, and served in North Africa and Europe during World War II. He was a surgeon during the Korean war. Binkley was a member of the Denver and Colorado Medical Societies.

Frank Burns of Montrose, Colorado, died on July 20, 1981, in Saudi Arabia as the result of an auto-truck accident. Dr. Burns, an ophthalmologist, was working at Al-Hada Military Hospital and Rehabilitation Center.

Mrs. Burns returned to Colorado. Internment was to be in Evergreen, Colorado. Dr. Burns was a member of the Curecanti and the Colorado Medical Societies.

John Bartlett Holyoke, M.D. died on August 14, 1981, in a climbing accident on Crestone Peak. He was 66 years old. Dr. Holyoke was a member of the Denver and Colorado Medical Societies. From 1976 until his death, Dr. Holyoke was a member of the staff of St. Joseph Hospital's department of pathology. He was chairman of the pathology department at St. Joseph from 1966 to 1976.

Born in Madrid, Nebraska, on May 1, 1915, Holyoke graduated from Omaha Central High School and the University of Nebraska School of Medicine. He served his internship at the University of Colorado Medical Center and took residencies in pathology at the Hitchcock Clinic in Hanover, N. H., and at the Mayo Clinic in Rochester, Minn.

Dr. Holyoke was a mountain climbing enthusiast all of the years he lived and practiced in Colorado. Until 1978 he held the speed record for climbing Wyoming's Grand Teton. He had also climbed all of the Colorado peaks of 14,000 feet elevation or higher. Dr. Holyoke's remains were cremated and the ashes strewn in the Sangre De Cristo Mountains

of southern Colorado.

Dr. Holyoke is survived by his wife, the former Alice Kingsbury Millet, three daughters, Margaret Meis, Denver, Julie Holyoke Marangoni, Florence, Italy, and Polly Holyoke, Boulder, a brother, Edward Holyoke, Omaha, Nebr., and two grandchildren.

Elmer A. Larson passed away at his home at the age of 77 on March 20, 1981. He graduated from the University of Iowa in 1929, and interned at Municipal Hospital in Washington D.C. From 1972 to 1976 he was the college physician at Cornell College. Dr. Larson was a member of the Iowa Medical Society, Colorado Medical Society, and American Academy of Family Practitioners. While living in Colorado, and semi-retired, he was an associate at Aurora Presbyterian Hospital, and worked with the AMA for three years attending health clinics around the state. Dr. Larson was also a member of the Fifty Year Club in 1979.

Francis Poynter Meyer Jr., of 1300 S. Parker Road, Denver, died July 22, 1981, at Fitzsimmons Army Medical Center after a long illness. Dr. Meyer was 66.

Dr. Meyer was born June 17, 1915, in St. Joseph, Missouri. He received his B. S. degree from Duke University and graduated from Duke University School of Medicine in 1939. He served his internship and residency at Temple University Hospital in Philadelphia and specialized in pediatrics at St. Bartholomew Hospital Medical School at the University of London in England. Following World War II service with the U. S. Army Air Corps as a flight surgeon, he entered

private practice in St. Petersburg, Florida, was Superintendent of the Sunland State Home in Orlando, and then served as Assistant to the Dean of Duke University School of Medicine.

After moving to Colorado, Dr. Meyer served as Vice President of the Colorado State Board of Basic Science Examiners, and also served as Superintendent of the Colorado state homes and training schools. Dr. Meyer served as Chairman of the American Red Cross fund drive in Denver, as well as a consultant to the Governor's Commission on Mental Health. He also served on the Board of the Colorado Mental Health Association and was Chairman of the National Health Committee. Dr. Meyer was a member of both the Denver and the Colorado Medical Societies.

Stuart Werner Smith, who lived at 1666 S. Fairfax St., died unexpectedly at his home. He was 63.

He was born Oct. 20, 1917, in Cleveland and attended school there and in Ravenna, Ohio. He graduated from Allegheny College in Meadville, Pa., and received his M.D. from Western Reserve Medical School in Cleveland.

Dr. Smith married Sallye M. Wrye Sept. 20, 1947, in Washington. The next year he became an Associate Professor of Anatomy at the University of Colorado School of Medicine, with which he was affiliated until his death.

He was a member of the American Association of Anatomists and The American Association for the Advancement of Science.

Surviving, in addition to his wife, are four daughters, Carol Ann Smith
(Continued on next page.)

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(Continued from previous page.)

of Denver, Dr. Susan Patricia Smith of Durham, N.C., Julie Lynn Smith of Phoenix and Lori K. Funk of Denver. Friends may contribute to the Stuart Werner Smith, M.D., and Michael Christopher Smith Memorial Fund at Children's Hospital, East 19th Avenue at Downing Street, Denver 80218.

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(Continued on next page.)

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(Continued from previous page.)

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OCTOBER 12-13, 1981: South Dakota Perinatal Association Sixth Annual Perinatal Conference: Holiday Inn, Spearfish, SD. 9.6 hours credit applied for. Guest speakers include: Preston Diltz, MD, John Grossman, MD, George McCracken, MD, Lu-Ann Papile, MD CONTACT: Margo Varcoe, R.N., S.D.P.A., 1100 S. Euclid, Sioux Falls, SD 57105. CALL: (605) 339-6578. 781-23-1b

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SCIENTIFIC/SKI MEETING: The Northwestern Medical Association convenes for its 35th Annual Meeting at Sun Valley, Idaho, from February 8-12, 1982. Diabetes and related vascular, neurologic, eye and ENT problems, ski injury prevention, and high altitude physiology will be discussed by experts. Approved for 10 CME Category I credits. Registration 3-5 p.m., February 8, Challenger Inn, Sun Valley. Non-members' registration \$100. For more information write to Norman Christensen, MD, Sec. Northwestern Medical Association, Inc. 2456 Buhne Stree, Eureka, California 95501. 781-20-2b

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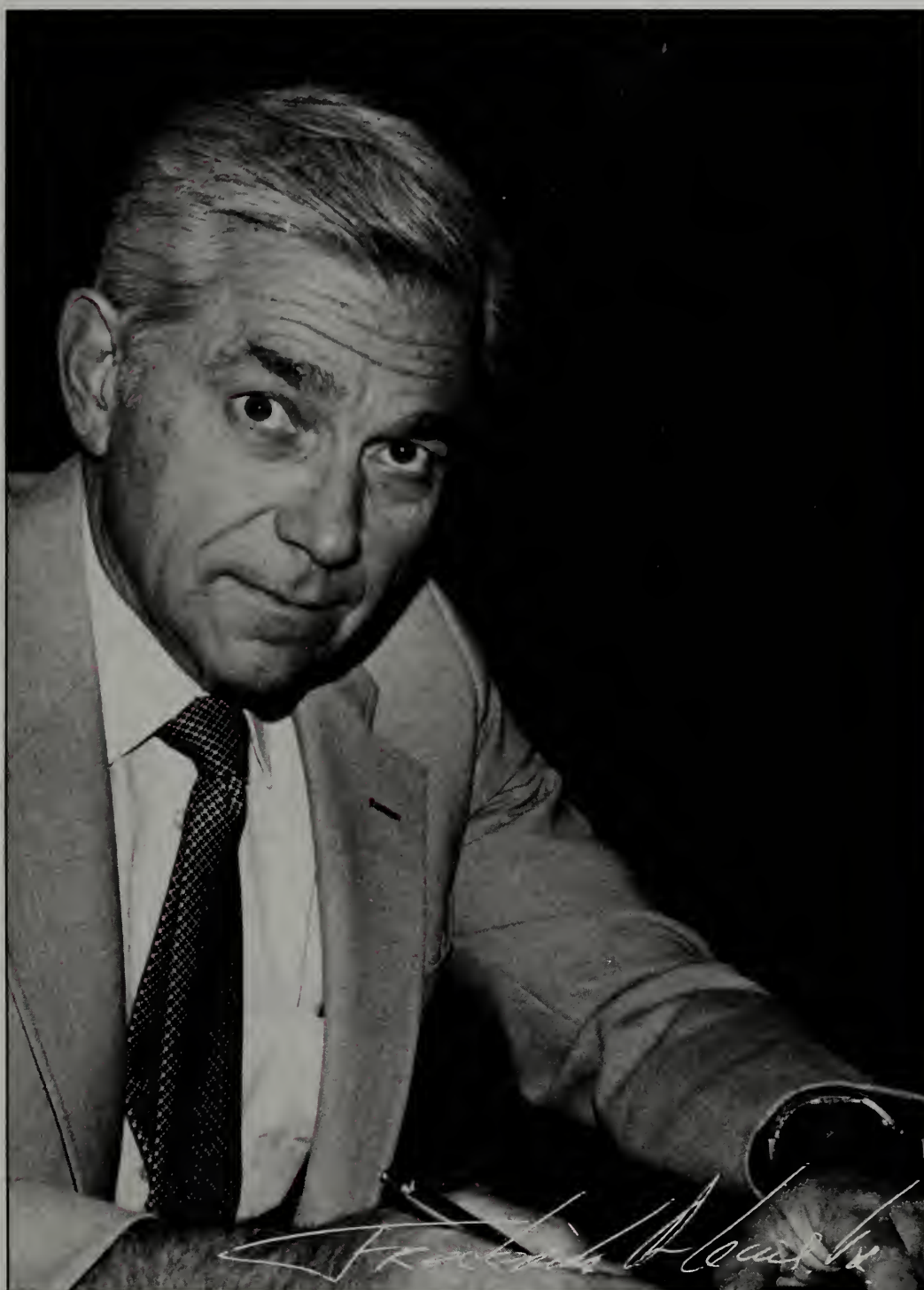
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Volume 78, Number 10



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Cover Story:

Frederick A. Lewis, Jr., MD, is the newly-installed President of the Colorado Medical Society, after what he called one of the most intensive training programs he had experienced since medical school.

Dr. Lewis referred to his past year as President-Elect, serving with President K. Mason Howard, MD, during 1980-81. Dr. Lewis said he felt he had been better prepared for "the job ahead" than any of his predecessors in the presidency. He has worked closely with Dr. Howard and members of the staff of CMS throughout the year.

Dr. Lewis comes to the leadership of CMS well prepared in his own right, having served as President of the Denver Medical Society in 1976-77, and having been active in so many areas of Society affairs, including council and committee work throughout his 23 years membership. He assured members of the House of Delegates in his inauguration address that he had specific questions about "the future of medical practice," and looked forward to working with Merlin Otteman, MD, the President-Elect, during this next year.

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By Carl J. Johnson, MD, Denver.

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president's letter



One of the interesting aspects of the job of President of Colorado Medical Society is the opportunity to attend various meetings around the country. Periodically in this column I will report on the highlights of these meetings. As you know, we are likely to see a number of significant changes in medicine over the next several years and the more information which Colorado physicians have, the better prepared we should be to meet challenges

which lie ahead. Recently, I attended the AAPSRO Annual Session as the Delegate from the Colorado Foundation for Medical Care and would like to relate some of my impressions.

Somewhat to my surprise there seemed to be a general consensus that the PSRO program was winding down and that the only real uncertainty was when (not whether) it will cease to be funded. There is apparently little doubt that the Administration plans on making sweeping changes in the health care delivery system in an effort to

decrease the federal government's outlay for health care. Medicare and Medicaid is budgeted for \$75 billion in fiscal year '82, even with the cuts which have been made. Some PSROs will continue to be funded until alternative strategies have been developed but this will be, at most, another one to two years, and then the entire program will be scrapped.

This has significant implications for Colorado physicians. It suggests that PSRO is a dead issue and that we should not waste any more time arguing or squabbling about it. We need to put it behind us and begin to plan for the future. The CFMC will no longer represent "federal intervention into the private practice of medicine," will no longer be bound by federal rules and regulations, and can be shaped by us into an organization which represents and serves the interests of Colorado physicians. The Foundation was created by Colorado doctors prior to the advent of PSRO and can serve us after the demise of PSRO.

Interestingly, almost the entire agenda of the AAPSRO meeting was devoted to various aspects of private review. Obviously, one reason for

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PSRO's moving into the arena of private review is to insure the perpetuation of the organizations involved. If this were the only reason for the shift, it would be insufficient to warrant the support of Colorado physicians.

From a physician's point of view, the real issue is whether or not some form of peer review is going to be required or desirable in the future. If it is, then it becomes imperative that we ensure the review is performed by physicians working in an organizational structure which is responsible to Colorado doctors.

At the meeting, the point was made over and over that private review should not be marketed as a cost-containment mechanism. Instead, it should be marketed as a mechanism to insure accountability of physicians, to provide quality assurance and to certify the necessity and appropriateness of care rendered. In other words, private review would guarantee the purchaser (be it a corporation, business, labor union, trust, etc.) that the right patient was in the correct institution for the proper length of time and, while there, received the appropriate treatment.

If the Administration is successful in promoting the "competitive model," there will be increased pressure within each competitive group to cut costs. This may raise the spectre of underutilization and undertreatment. If medical care is to be treated like any other commodity in the open market, it would appear that there will be a need for a quality control mechanism.

If you believe that as medicine becomes decreasingly regulated, business and industry will increasingly demand some mechanism for quality control, then you are in favor of the CFMC expanding its private review efforts. If you do not believe that this will happen and do not think that organized medicine has any responsibility to monitor the quality of its product, then you will not favor increased private-sector review.



Medical Student Component Society

by John Shonk, Jr., MS-II
Secretary-Treasurer

The Student Medical Society has gotten off to a first-rate start for the new academic year, with increased membership, blood pressure screenings and educational opportunities.

Our membership drive meeting on August 27 initiated the school year with Dr. Duane Spaulding, Mary Ruth Salazar, President, Don Putzier, Vice President, AMA Delegate Lee Ann Pearse and myself discussing various aspects of CMS and AMA membership.

We would like to offer special thanks to Dr. Spaulding for taking time to share his very informative views on the value of CMS in the residency years.

The membership drive has proven quite successful as we have acquired 29 new CMS members, including 22 freshmen, 16 sophomores and one junior. Of the new members, 23 of them joined the AMA as well, including 19 freshmen, 3 sophomores and one junior. Already, several of the new members are becoming involved in the day-to-day functions of our chapter. We are expecting more new members at the start of the calendar year.

The blood pressure screening received such good volunteer response that we added a second site at the Josephine and Colfax Safeway store to accompany the site at the 14th and Krameria Safeway, both in Denver. Eleven members participated at the two screenings, including sophomore Carla Cervený, Karen Fukutaki, John Kucera, Don Putzier, Mary Ruth

Salazar and Rachel Wood. Freshman participants included Chris Gray, Dave Hahn, Dave Hanson, Wendy Kazman and Diane Lujan. At the two sites a total of 432 people were screened. A November 21st screening is currently being organized by Don Putzier, who was also responsible for the September screenings.

Our September 24 meeting was organized in relation to the CMS primary goal of communications. We are trying to condense and make available to our members any and all information about Colorado Medical Society they may find useful. The freshmen members have shown a definite interest in the project and several have already become involved.

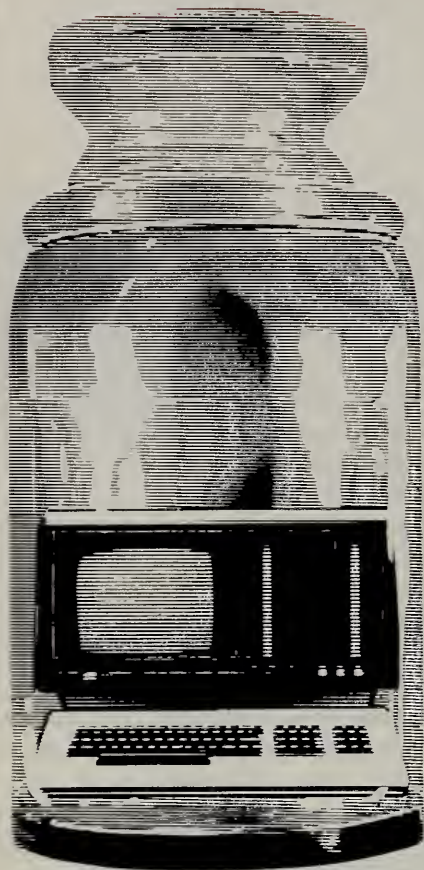
Educational programs are under way for the year and included a multi-media first-aid course, conducted by Mary Ruth Salazar, on October 1st for five CMS members. Opportunities for the participants to become instructor-certified will soon be available. The Student Medical Society will be able to provide first-aid education in the medical school and in the community. Other educational programs are being planned for the year.

Our next two meetings of the Medical Student component are scheduled for 12:00 o'clock Noon on October 28, and November 19, 1981.

Denver Medical Society

Early in 1981 the Denver Medical Society's Special Committee on Aging completed a physician survey in Denver on the utilization of home
(Continued on next page.)

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(Continued from previous page.) health agencies. The findings presented evidence that physicians needed and would use help from discharge planners of hospitals in referring their office-practice patients to appropriate agencies.

A special sub-committee was formed to devise a card which could be mailed to all members of the Denver Medical Society which they could keep in their offices and which would give them helpful information and specific persons to contact. 18 hospitals agreed to participate in referring physicians to home health care services by listing their Clinical Social Worker, Home Care Nurse Coordinator or both on the card with telephone numbers for doctors to call for consultation.

The front of the card contains a brief listing of what home health services are available in the Denver area, why such services should be used, what programs (including insurance programs) pay for the service to patients and how to obtain the services.

Both sides of the card are shown in reduced form below. The cards were printed and sent in August by the Denver Medical Society as a service to its members.

Peter C. Hoch, MD, Installed as DMS President

Peter C. Hoch, MD, a Denver pediatrician, was installed, at the October 6th Annual Meeting, as President of the Denver Medical Society. Dr. Hoch succeeds outgoing president J. Phillip Nelson, MD.

Dr. Hoch was born in Basle, Switzerland, and received his medical degree from the Columbia College of Physicians and Surgeons in New York in 1943. He took his internship at the Gorgas Hospital in the Canal Zone and his residency at Children's Hospital of Denver. Dr. Hoch has been practicing in Denver since 1948, and has been very active in Denver Medical Society. He practices in the Department of Pediatrics at the Gates Clinic, and has been with the Gates Clinic for 18 years.

HOME HEALTH A GOOD ALTERNATIVE

WHAT ARE HOME HEALTH SERVICES?

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HOW TO OBTAIN SERVICES FOR YOUR PATIENTS

For suggestions and advice on locating and using the services of home health agencies, telephone or visit the individuals at the hospitals listed on the other side of this card. They will assist you and their staff physicians in arranging for services.

or look for an agency listing in the Yellow Pages under
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AUGUST 1981

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NOTES

"MedMonth"

LET ME TELL YOU WHAT IT IS!

(A communications report, October, 1981)

As recently as the spring of 1981, the Public Information Committee of CMS was wrestling with the problem of how to better inform CMS members of what is happening within their own profession, and then relating this information to their patients.

Several campaigns were considered, and the one which has come to fruition with this October issue of COLORADO MEDICINE is "Ask Me About Medicine," including "Med/Month."

You will see a notification in the front portion of this magazine concerning "Ask Me About Medicine," directing you to a monthly calendar which will be appearing in each issue of COLORADO MEDICINE. The calendar is designed to be removed from the magazine and used throughout the coming month.

WE DON'T NEED TO BE REMINDED..... that the magazine has been terribly behind schedule for some (quite a few) months; however, with the production of the November issue, COLORADO MEDICINE will be back on schedule with an early publication. Therefore, our monthly publication of the "Med/Month" calendar will be timely and well ahead of schedule for your use.

What is the purpose? First, the calendar will give you a ready pocket reference to the latest issues concerning private practice medicine, allowing you quick access to the facts. You are urged to make use of this information in your day-to-day activities and conversations. You will be doing yourself and your fellow professionals a tremendous favor by speaking out about medical practice.

Each issue of "Med/Month" will give you facts about the costs of health and medical care and treatment, current national and state legislative issues, information about Medicaid and Medicare, about HHS, about current HMO/IPA trends, about efforts to control medical costs, issues of interest to specialty practices, and much more.

No, "Med/Month" will not take the place of your hospital and office appointment book, but you'll find it a handy pocket reminder and note pad, as well as a quick look at those dates and issues which concern you, individually.

You will also note that the CME Calendar, which is published each month in COLORADO MEDICINE, is now greatly expanded. The Communications Department is attempting to give you as much useful information to your practice as possible, in a timely manner. The CME calendar will be

carrying information well into the next six months, which should allow you the luxury of planning your CME activities and trips far in advance. The editors know that this is crucial to your being able to place these CME opportunities in your schedule.

We hope that the services of COLORADO MEDICINE magazine can be expanded and improved with each new issue. One of the primary goals for the magazine is to be on time, timely, and useful to its readership. Your comments and suggestions are also welcome. Let us hear from you.

NEW MEMBERS

ARAPAHOE MEDICAL SOCIETY

Jeffrey R. Scott, M.D.
8200 E. Belleview Ave., Suite 204
Englewood, CO 80111

Michael S. Swanson, M.D.
4257 So. Parker Rd.
Aurora, CO 80014

BOULDER COUNTY MEDICAL SOCIETY

Linda D. Backup, M.D.
Longmont Clinic
1725 Mountain View Ave.
Longmont, CO 80501

Irene Olijnyk, M.D.
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Longmont, CO 80501

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Denver, CO 80207

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Denver, CO 80204

Glenn P. Wallis, M.D.
255 Union Blvd., Suite 310
Lakewood, CO 80228

CURECANTI MEDICAL SOCIETY

Gary G. Auxler, M.D.
947 So. Fifth
Montrose, CO 81401

Joan D. Pixler, M.D.
164 Colorado Ave.
Montrose, CO 81401

William R. Trimble, M.D.
222 So. Nevada
Montrose, CO 80401

EL PASO COUNTY MEDICAL SOCIETY

John W. Lavoo, M.D.
104 E. St. Vrain, Suite 10
Colorado Springs, CO 80903

LAKE COUNTY MEDICAL SOCIETY

James F. Pagel, M.D.
Box 2234
Granite, CO 81228

MESA COUNTY MEDICAL SOCIETY

Charles F. King, M.D.
Box 268
Colbran, CO 81624

OTERO COUNTY MEDICAL SOCIETY

Roland W. Wilkins, M.D.
111 W. Third St.
La Junta, CO 81050

PUEBLO COUNTY MEDICAL SOCIETY

David N. Havlin, M.D.
Southern Co. Family Med.
1600 W. 24th St.
Pueblo, CO 81003

UCMC STUDENT MEDICAL SOCIETY

Diana L. Lujan
4075 E. 12th Ave., #202
Denver CO 80220

Eileen M. Nobles
2445 So. Colorado Blvd, #325
Denver, CO 80222

William W. Stevens, III,
1029 Luke St.
Ft. Collins, CO 80524

NEW OFFICERS

Terms Expire January, 1983

Montelores County Medical Society
(Delores, Montezuma)

PRESIDENT

Kent Aiken, MD
P.O. Box 668
Mancos, CO 81328
533-7704

VICE-PRESIDENT

Jeryl Frye, DO
33 No. Elm Street
Cortez, CO 81321
656-7271

SECRETARY

Paul D. Bostrom, MD
1011 No. Mildred Road
Cortez, CO 81321
565-3713

CLEAR CREEK VALLEY MEDICAL SOCIETY

PRESIDENT

Eugene L. Weston, MD
2550 Youngfield St.
Lakewood, CO 80215
233-6287

PRESIDENT-ELECT

Chester M. Cedars, MD
1930 So. Federal Blvd.
Denver, CO 80219
934-5729

VICE-PRESIDENT

Chester M. Cedars, MD
1930 So. Federal Blvd.
Denver, CO 80219
934-5729

SECRETARY

Ronald Tegtmeier, MD
9950 W. 80th Ave., #11
Aravada, CO 80005
424-1174

MESA COUNTY MEDICAL SOCIETY

Terms expire 9/82

PRESIDENT

Bruce Ward, M.D.
St. Mary's Hospital
P.O. Box 1628
Grand Junction, Colo. 81501
244-2209

PRESIDENT-ELECT

C. K. Wanebo, M.D.
790 Wellington
Grand Junction, Colo. 81501
243-3061

SECRETARY

Dorr H. Burns, M.D.
731 Bookcliff Avenue
Grand Junction, Colo. 81501

MORGAN COUNTY MEDICAL SOCIETY

Terms expire 9/82

PRESIDENT

Malcolm J. Dickerson, M.D.
P.O. Box 305
Brush, Colo. 80732
842-2871

SECRETARY

John Collins, M.D.
625 W. Platte Avenue, Suite A
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867-9624

NORTHEAST COLORADO MEDICAL SOCIETY

Terms expire 9/82

PRESIDENT

James Ley, M.D.
Box 248
Haxtun, Colo. 80731
774-6187

VICE-PRESIDENT

Robert Marlow, M.D.
Box 1191
1405 So. 8th Avenue
Sterling, Colo. 80751
522-3304

SECRETARY

Curtis Kimball, M.D.
Box 1191
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Sterling, Colo. 80751
522-5720

SOUTHEASTERN COLORADO MEDICAL SOCIETY

Terms expire 9/82

PRESIDENT

Keith F. Krausnick, MD
P.O.Box 352
Lamar, CO 81052
336-9051

VICE-PRESIDENT

William R. Troup, MD
137 Kansas St.
Walsh, CO 81090
324-5253

SECRETARY

Edwin C. Likes, MD
800 So. Main St
Lamar, CO 81052
336-4335

American Association of Medical Assistants, Inc.

Colorado Society — Capitol Chapter

“Child Abuse — Our Responsibility”

Saturday, January 9, 1982

9:00 am - 2:00 pm

Humphreys Auditorium

University of Colorado

Health Sciences Center

Speakers: • John Sheppard, Investigator, Arapahoe County Sheriff's Department
• Ed Nelson, Sheriff, Arapahoe County

8:30 am - 9:30 am.....Registration
9:00 am - 11:00 am.....Speaker
11:00 am - 12:00 Noon.....Luncheon Break
(A BOX LUNCH WILL BE SERVED)
12:00 Noon - 2:00 pm.....Speaker

Continuing Education Unit credit has been applied for. Registration Costs: \$20.00 members, \$25.00 non-members. Registration costs include box lunch. Those attending who wish to have CEU credit will be charged \$2.00 for members and \$3.00 for non-members for CEU registration.

Make checks payable to: Capitol Chapter Colorado Society of Medical Assistants

Mail registration to:

Boni Bruntz CMA-A
13641 East Dakota Ave.
Aurora, Colorado 80012
Home phone: 343-0163
Office: 761-2870

Registration Form

AAMA Colorado Society, Capitol Chapter — “Child Abuse: Our Responsibility”

Name _____ Member ☐ Non-member ☐

Address _____ Zip Code _____

Home Phone _____ Work Phone _____

Social Security No. _____

Registration Deadline January 6, 1982

Ask me about medicine.

*A monthly service, day-by-day,
prepared by the Public Information Committee,
Colorado Medical Society.*

*This pocket reminder is published and
distributed on behalf of member physicians
and their patients to inform them of current
issues in health care. We ask that you carry it
with you, refer to it often and become an
active spokesman in our effort to provide
timely, factual information.*

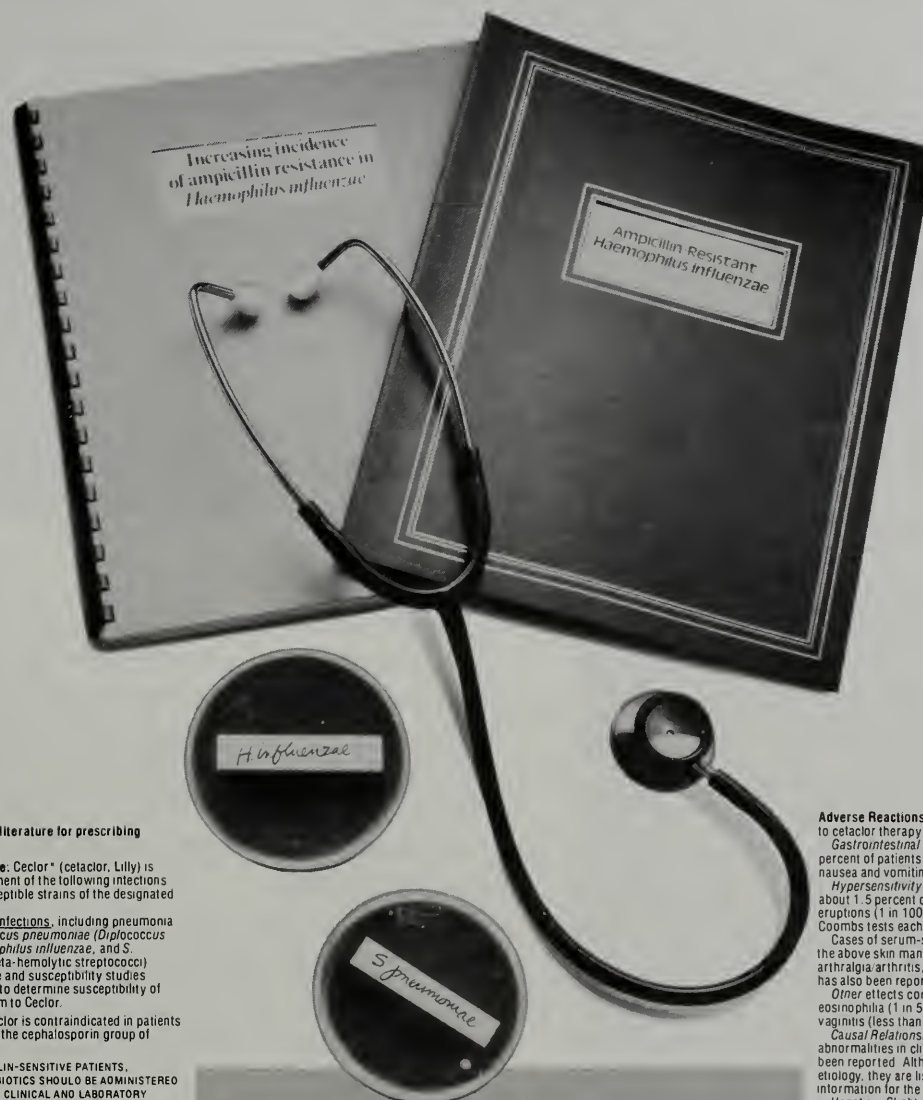
*For more information, contact the Division of
Communications, Colorado Medical Society,
(303) 861-1221.*

November 1981

New...This Month...for C/M Readers!

Be sure to use the newest service feature of *Colorado Medicine* in this issue: a monthly account of the latest socio-economical information concerning your medical practice. Just tear out the handy, day-to-day pocket calendar for your own use and information.....be a part of "Ask Me About Medicine!"

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy:—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy:—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain:—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1003808)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
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3. Antimicrob. Agents Chemother., 13: 584, 1978.
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5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 17: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

100061

HYPERTENSION

ADULT ONSET DIABETES

CARDIOVASCULAR DISEASE

The CONTINENTAL HEALTH ENHANCEMENT CENTER (CHEC), near Denver and Boulder, is a beautifully appointed facility offering exceptional programs. With a staff of three full-time physicians, a number of specialty consultants, exercise physiologists, psychologists and a registered nutritionist, personalized programs are designed for your patients based on your recommendations. Full reports are furnished to you on their progress with recommendations for follow-up.

respond **REMARKABLY*** to a carefully organized and structured program in an in-residence rehabilitation-health enhancement program emphasizing medically supervised, directed and controlled nutrition, physical and psychological fitness together with stress management.

These results are obtained by extensive patient participation reinforced by didactic educational sessions, insuring a high degree of patient compliance after leaving the facility.

For information or to arrange a visit to the facility, call (303) 665-9020 and ask for a staff physician.

References:

Barnard, J.R. et al. Effects of An Intensive, Short-term Exercise and Nutrition Program on Patients with Coronary Heart Disease. *J. of Cardiac Rehab.* 1981

Council on Scientific Affairs, American Medical Association. Physician-Supervised Exercise Programs in Rehabilitation of Patients with Coronary Heart Disease. *JAMA* 245 1463-1466. 1981

Glueck, C.J. et al. Diet and Coronary Heart Disease. Another View. *NEJM* 298 26, 1471-1474. 1978

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Miranda, P.M. Horwitz, D.L. High Fiber Diets in Treatment of Diabetes Mellitus. *Ann Intern Med* 88 482-486. 1978

Nerem, R.M. et al. Social Environment as a Factor in Diet-Induced Atherosclerosis. *Science*. 208. 1475-1476. 1980

Soman, V.R. et al. Increased Insulin Sensitivity and Insulin Binding to Monocytes after Physical Training. *NEJM*. 301 22. 1200-1204. 1979

Vessell, E.S. Exercise as Protection Against Heart Attack. *NEJM*. 302 18. 1026-1028. 1980

Vesselinovitch, D. et al. Reversal of Advanced Atherosclerosis in Rhesus Monkeys. I. Light Microscopic Studies. *Atherosclerosis*. 23 155-176. 1976

Williams, R.S. et al. Physical Conditioning Augments the Fibrinolytic Response to Venous Occlusion in Healthy Adults. *NEJM* 302 18. 987-991. 1980

Highlights of the Annual Session of the House of Delegates, September 9-11, 1981, held at Keystone Lodge, Colorado.

Organizational

—Supports the Building Committee and Board of Directors in its endeavors with respect to land purchase and building plans for Executive Office; recommended that specifics on plans for proposed building be presented at next House meeting if concrete plans are available. Should plans develop sooner, presentation should be made at special meeting of House; recommended that the Building Committee be enlarged to include more members from Denver Metro area.

—Reaffirmed CMS Goals for 1980-81 and adopted priority programs for 1981-82.

—Inaugural Address of Dr. Frederick Lewis outlined steps to ensure the quality of care and the medical profession; urged unification of the profession by increasing membership at state and AMA levels; stronger support of COMPAC and, by extension, AMPAC; adoption of prioritized goals and programs for CMS; support of the Colorado Foundation for Medical Care.

—A resolution directing that any resolution at the September 1981 Annual Meeting be null and void after 1985 Annual Meeting unless reconsidered at 1985 Annual Meeting and reaffirmed by the House of Delegates was defeated. House recommended a current policy manual for officers of the Society, prepared administratively, and that all resolutions should include a time limitation stipulated by the author.

—Adopted a resolution directing that CMS make known as a goal the acquisition of 65 additional AMA

members within its component bodies; provide components with whatever materials and information available and set a deadline for accomplishment.

—Adopted amended Articles of Incorporation and amended Constitution.

—Adopted amendments to Bylaws including the following: change "Active Members on leave" to "Active Members Emeritus-Annual;" create new classification of "Inactive members;" change and composition of Committee on Committees, to include annual sunset evaluation of all CMS councils and committees; authorize Board of Directors to create and abolish committees; councils transmit reports to the House through the Board; council members are elected by the House.

—Adopted additional Standing Rules of the Colorado Medical Society, including the following: AMA Delegation shall schedule Pre-AMA Conference to receive pertinent instructions; establish position of Historical; provide for open meetings and Executive Sessions of the CMS Boards, Councils and Committees; establish CMS Organizational Study Committee; Councils submit recommendations concerning policy to the Board; terms and size of Council members from five Director Districts specified; lists five councils and charges; Committee members to represent all geographic portions of state, with terms of membership to expire annually; Chapter on Recall of persons elected by the House; Chapter of Qualifications for being elected as President-elect, Treasurer, Speaker, Vice Speaker, and AMA Delegates and Alternate Delegates; provide for nominations by petition; rotation of President-elect from three regions of state; change of component society membership; orientation of new members; appeal from component society decisions.

Interprofessional Relations

—Agreed that a mechanism be developed to help mediate staff privilege disputes upon a case-by-case basis, based on testimony that such intraprofessional problems do exist and the possibility of these problems intensifying. Recommended that the Council on Interprofessional

Relations should extend its present areas of responsibility and capability to deal with these problems. The Medical Society's ability to assist in any local dispute should be more widely publicized.

—Approved a statement on Prescribing of Schedule II Non-narcotic Controlled Substances to be sent to the BME with CMS endorsement.

—Adopted a resolution which supports CMS extending reasonable assistance to the AAMA by supporting activities to encourage membership; cooperating with AAMA in its education efforts when those efforts promote more cost efficient practice management; and publishing meeting notices in Colorado Medicine.

Legislation

—Adopted a resolution concerning the Colorado State Board of Medical Examiners which requests a general report from the BME to the CMS House of Delegates at each Annual Session to include information about the number and disposition of cases being heard; directs the CMS to urge the Joint Budget Committee to provide adequate funding so that the BME has adequate legal and administrative staff; directs CMS, through the CMS Judicial Council, the Patient and Professional Relations Division and other appropriate auspices, to organize an advisory body to the BME on standards of practice, when so requested.

—Encouraged increased communications to the component societies and their members from the staff of Government Affairs Division, society presidents and the Society Legislative Chairman.

—A resolution concerning Colorado spending limitation was defeated.

Medical Service

—Referred the proposed CMS policy statement regarding "Physician/Paramedic Interaction in the Field" back to the Council on Medical Service for further consideration.

Professional Education

—Approved a Long-Range Educational Plan for CMS and recommended that CMS implement the plan as written. Recommended the plan be used as a guideline for other CMS Councils.

(Continued on next page.)

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Socio-Economics

—Recommended that CMS legal counsel assess the legality of establishing a Relative Value Study.

—Directed the Council on Socio-Economics to promote and continue the task of already established committees specifically in areas of Private Health Insurance, Industrial Liaison, and Cost Efficiency.

—Requested an investigation be conducted into new alternative forms of health care delivery relating to the pro-competition models.

—Approved a policy statement adopted by the Voluntary Effort Steering Committee and recommended referring it back to the Voluntary Effort Steering Committee with a recommendation that medically safe procedures performed under proper circumstances in physicians' offices be reimbursed by third party payers.

—A resolution concerning Radial Keratotomy was defeated.

Professional Liability

—Approved a report concerning the CMS professional liability program, specifically the establishment of the CMS Professional Liability Trust. Emphasized that there be accountability of the Trust performance to the CMS Board of Directors on a monthly basis and to the House of Delegates at each regularly scheduled meeting; that physician control be maintained by the fact that the Board of Trustees serve at the pleasure of the CMS Board of Directors subject to confirmation by the House of Delegates; and that in considering the definition of the Board of Trustees of any future captive organization, the CMS Board of Directors embody the concepts of finite terms and staggered terms to insure continuity. The House recommended instead of an eleven-member Board of Trustees it should be a nine member Board.

—Adopted a resolution which authorized expanding the composition of the Risk Management Committee. Resolution supplements action taken by the Board which approved expanding the committee to five members; considering a family/general practitioner for a future posi-

tion; an ad hoc member eventually to become the fifth member; setting five year terms; rotating one member each year in the future; appointing two additional ad hoc members in the near future.

Colorado Foundation For Medical Care

—Approved the Annual Report of the Colorado Foundation for Medical Care.

—Approved a resolution reaffirming the CMS House of Delegates' support in the concept of physician peer review and the direct involvement and participation of Colorado physicians in the peer review process.

If you wish further details, a copy of the transcript of the House of Delegates' proceedings and Handbook Report are on file at the CMS Executive Offices.

The following Physician Members of Colorado Medical Society were recognized for having practiced medicine for fifty years.

Arapahoe Medical Society

Lawrence A. Berg
Wesley C. Eiselle

Denver Medical Society

Abern E. Bowers
Harold I. Goldman
Egbert J. Henschel
Hellen E. Maytum
Bernard C. Sherbok

Larimer County Medical Society

Lawrence D. Dickey
George E. Garrison

Pueblo County Medical Society

Scott A. Gale

Boulder County Medical Society

James D. Stewart

Otero County Medical Society

Clayton C. Weber

Weld County Medical Society

Robert T. Porter
Harley S. Rupert

Socio-Economics Survey of Reagan Administration Omnibus Budget Reconciliation Act

Report from the Division of Socio-Economics, to the Board of Directors, Colorado Medical Society, October 9, 1981

The Reagan Administration is making good on its promises to the nation's governors to give them the administrative flexibility they want to run their Medicaid programs under the constraints of reduced federal funding. Outlined here are summaries of some of the Medicare-Medicaid provisions.

Section 2143—Lowering Section 223 limits to 108 percent of mean.

Medicare is to lower reimbursement limits on hospital routine costs from 112 percent to 108 percent of the mean costs of each group of hospitals, effective for accounting periods after 9-30-81 in proportion to part of period after that date. Exemptions, such as for sole community providers, and exceptions continue to be permitted.

Section 2164—Eliminating Matching for Certain Lab Tests

Medicaid matching payments would be denied for any lab tests not specifically ordered by the attending physician, effective October 1, 1981.

Section 2171—Limiting State Coverage for Medically Needy Population

Current requirements (effective August 13, 1981) on the scope and mix of services to be offered the medically needy have been replaced with the following: if a state provides coverage to any group, ambulatory care must be provided to children and prenatal and delivery services for pregnant women; if a state provides institutional services for any group, it must also provide ambulatory services; if care in ICF facilities for the mentally retarded is covered, then the same mix of institutional and non-institutional services as under previous law must be provided. Ambulatory services are intended to be defined to include physicians, clinics, nurse practi-

tioners, dental and preventive services. States are no longer required to provide comparable services to both the medically needy and categorically needy populations, but now have flexibility to establish different eligibility criteria and scope of services to address needs of different population groups.

Section 2172—Medicaid Reimbursement to Hospitals

Replacing Medicaid's use of reasonable cost reimbursement (regulation promulgated October 1, 1981, if HCFA published regulations on or before that date), not to exceed cost as defined under Medicare, is a requirement that the states, in developing their payment rates, take into account the special needs of hospitals serving a large number of low-income persons. States are supposed to set reimbursement policies which meet the costs that must be incurred by efficiently administered hospitals in providing covered care and services to Medicaid eligibles as well as costs incurred to meet state and federal requirements. It is also intended that states be allowed limited payment increases to increases for goods and services purchased by hospitals, as measured by an index such as the national hospital input price index.

Section 2174—Removal of Medicaid Reasonable Charge Limitation on Medicaid

Effective October 1, 1981, the current requirement that state Medicaid payments for physician services and certain medical supplies and lab services cannot exceed reasonable charge levels set under Medicare is repealed.

Section 2175—Limitations on Freedom of Choice

Effective October 1, 1981, a state may require persons who overutilize services to use particular providers and to limit the participation of providers which the state finds, after opportunity for an administrative hearing, to have abused the program. Eligibles must have reasonable access to services of adequate quality, however. The Secretary may also waive other Medicaid requirements. HHS must approve waiver requests if it finds them cost effective, efficient and consistent with program requirements. Using a case manage-

ment approach, a state may restrict access to primary care services if such a restriction does not impair access to services of adequate quality. A locality may act as a broker to assist eligibles to select among competing health plans. States may share with recipients' savings from use of more cost effective delivery arrangements. Restricted access to providers may be permitted except in case of emergencies. Providers that participate must accept and comply with reimbursement, quality and utilization standards under the state plan. Such restrictions are to be consistent with access, quality and efficient and economic provision of health care and are not to discriminate among providers on grounds unrelated to their effectiveness and efficiency. It is intended that when evaluating waiver requests, HHS will apply performance standards for cost effective provision of services, based on such criteria as length of stay or cost per admission.

Section 2182—Limitation on Requirements for Collection of Third Party Payments

Effective August 13, 1981, states are no longer required to collect third-party liabilities in cases where the amount of reimbursement the state can reasonably be expected to recover is less than the costs of recovery.

Section 2161—Medicaid Payment Reductions & Offsets to States

Effective October 1, 1981, HHS plans to recodify existing requirements, not issue regulations, to implement the provisions reducing federal matching payments by 3 percent, 4 percent, and 4.5 percent in FY 82, 83 and 84, respectively. If a state keeps Medicaid spending at less than 109 percent of the previous year's estimated spending levels its scheduled reduction is offset dollar for dollar. In subsequent years, this target would be increased by the rate of increase of the medical care component of the Consumer Price Index. A state could also offset a reduction in federal payments equal to one percentage point for each of the following: operating a federally approved state rate review program; having a jobless rate higher than 50 percent of the national average; or collecting from fraud and abuse ef-

forts and third-party liabilities an amount in excess of 1 percent of federal matching payments. Excluded from these limits are: adjustments for prior years' claims, interest paid on past years' disallowances; offset payment received for spending less than target in previous years; and any of the reductions in federal funds a state receives that are imposed by this section.

Section 2178—Flexibility in HMO Participation in State Plans

Effective October 1, 1981, states are intended to be encouraged to contract with prepaid health plans provided that the plan is federally qualified or plan makes covered services to Medicaid enrollees accessible on the same basis as to other Medicaid eligibles in the area and has made adequate provision against risk of insolvency. Enrollees in the latter type of plans are not to be held liable for debts in case of insolvency. Modified is the current requirement that within three years of entering into a Medicaid contract with a state, an HMO must have an enrollment that consists of less than 50 percent Medicaid and Medicare eligibles. The ceiling is raised to 75 percent of enrollment and the ceiling can be waived for public HMOs. States may establish minimum enrollment periods for Medicaid patients of not more than six months for federally qualified HMOs. Savings realized because of the contracts with prepaid plans could be shared by the states with Medicaid patients by covering additional services.

Section 2104—Withholding of Payments for Certain Medicaid Providers

Effective August 13, 1981, HHS is to offset from reimbursements due to Medicare Providers overpayments made to them under Medicaid where the provider has been terminated or substantially reduced his participation in Medicaid. State Medicaid agencies are to be reimbursed from amounts recovered.

Section 2142—Limitation on Reasonable Charge for Outpatient Services

Effective August 13, 1981, regulations are to be issued to establish limits on costs or charges that will be
(Continued on next page.)

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considered reasonable for outpatient services provided by hospitals, community health centers or clinics and by physicians using those facilities. The limits are to be reasonably related to the reasonable charges in the same area for similar services provided in physicians' offices. The limits are not to apply to bona fide hospital emergency room services. Actual charges, made by physicians, not charges established as reasonable by Medicare, are to be used in setting the limits. HHS is to establish the limits only if they are feasible; exceptions to the limits are to be available in areas where physician services are not generally available

Deadline for Proposed AMA Resolutions

November 6 is the 30-day deadline for receipt of resolutions to be considered by the AMA House of Delegates at its Annual Meeting to be held December 6-9, 1981, in Las Vegas. If you have a resolution you wish to have introduced by the Colorado AMA delegation, please forward it to the CMS Executive Office by October 28, 1981.

Jobe Elected to Presidency of ACR

William E. Jobe, MD, of Littleton, Colorado, became the president of the American College of Radiology September 24, 1981, at the ACR annual meeting in Las Vegas.

Dr. Jobe, chairman of the department of imaging at Swedish Medical Center and Craig Spinal Cord Center, is a Denver native. He received his MD degree from the University of Colorado in 1957, served an internship at the University of Chicago, took his residency training in radiology at the University of Colorado and then became chief resident in 1961. Dr. Jobe was certified by the American Board of Radiology in 1962 in radiology, nuclear medicine, isotopes, and

physics.

Dr. Jobe has been active in the Arapahoe and Colorado Medical Societies, and has served as a member of the Board of Directors of Colorado Medical Society since

1980.

The ACR represents more than 17,000 physicians specializing in the use of x-rays and other imaging modalities for diagnosis and treatment.

Drug Fraud Alert

Editor's note: We realize that this monthly Drug Fraud Alert is intended, primarily, for pharmacists; however, it has proven beneficial in the past to alert physicians to the current drug fraud activities. We want physicians and their staff members be alert to possible activities affecting their own offices.

Drug Fraud Alert information is supplied by the Lakewood, Colorado, Department of Public Safety. For further information you can contact either the Lakewood Intelligence Division, 234-8581, or the Denver Police Department, Detective Division, Narcotics Investigation, at 795-4757.

Your attention is called to the following prescription fraud activities:

Drug—Ambenyl

Ambenyl Expectorant prescriptions are being forged and phoned-in throughout the metropolitan Denver area. Prime suspects at this time are two black males and a 19-year-old white female described as short and stocky with black hair, who sometimes carries an infant.

Someone using **Dr. Miguel Mog-yoros'** name and DEA number is calling in prescriptions for Ambenyl. Please verify all prescriptions with Dr. Mog-yoros, Kaiser Building, 232-1885.

If you receive any Ambenyl prescriptions from Dr. Mog-yoros during the next 2 to 3 weeks, they are unauthorized as Dr. Mog-yoros has agreed not to prescribe any Ambenyl during that time. Notify the police immediately. The police will try to apprehend the person who picks up the prescription.

Forged prescriptions have been

presented for Ambenyl Expectorant on the order forms of **Dr. K. Mason Howard, Dr. G. Gray Wells, Dr. Robert L. Kruse, and Dr. Ronald C. Ochsner**, 2090 So. Downing Street and 191 Orchard Road. In this case, the suspect was a dark complected Spanish American male, age 26 to 28, 5'8", 160 lbs. (stocky), black hair, "very calm" in demeanor. He was seen in a 1979 tan Oldsmobile Cutlass, license #CC-9810, Colorado. Owners of this car are two negro males, Ronald B. Quinn and Robbie L. McWilliams.

Drug—Dilaudid/Percodan

Recently, a white male, age late 20s, 5'11" tall, stocky build, light brown hair, claims to have kidney stones and has tried to pass two prescriptions for Dilaudid and Percodan. Order forms used are yellow in color, headed Internal Medicine Center, PC, 4545 E. 9th Avenue, **Dr. Huttner, Dr. Karsh, Dr. Katz, and Dr. Abrams**. Patient names used were Jeffrey Bouchner and Michael Ingalls.

Drug—Preludin

A forged prescription for Preludin on the order form of Drs. Ryan and Ryan, PC, 6900 West Alameda Avenue, was presented to a local pharmacist recently. Party was described as a black male, age 38, 6'2" tall and thin with black hair and wearing a cap. Please verify all Schedule II prescriptions with the doctor.

Drug—Tylenol #4/ Soma Compound

On a recent Saturday, a female calling herself "Toni" called in a prescription for Tylenol no. 4 #20 and Soma Compound #40 using Dr. Robert H. Wendorff's name. The patient name used was Donald Cary. Dr. Wendorff's office is not open on Saturday and he has no patient by this name.

Certificates of Service, 1981

Herbert J. Rothenberg, MD

After serving with the original Peer Review Committee, beginning in 1971, Dr. Herbert J. Rothenberg volunteered to continue service on the newly created Risk Management Committee in 1976, in the pioneering effort to educate and discipline physicians. Dr. Rothenberg continues to serve this committee steadfastly. Through all this, Dr. Rothenberg gives his services, despite the innumerable calls and letters, the time loss, expense and even indignity resulting from this Committee's work.

Of Dr. Rothenberg's faithful devotion to the Committee's work, in the words of a colleague, he "represents the epitome of a quality physician and an infinitely wise judge of not only medical practice but medical ethics. He deserves any honor which his fellow physicians can bestow upon him."

Robert G. Bosworth, Jr., MD

The respect given him by all who know him reflects the merit Dr. Robert G. Bosworth, Jr., has achieved during his long and devoted services to the Colorado Medical Society. Beyond all this, however, remains the list which includes Dr. Bosworth's name throughout 22 years of work in Council and Committee positions. In each of these positions, Dr. Bosworth's incisive suggestions often have penetrated moments of confused rhetoric to help solve the problem at hand.

Dr. Bosworth is further recognized for the many hours (which do not appear in any biography or curriculum vitae) in special calls by phone or in person to physicians, legislators and political candidates, explaining the positions and directions of the Colorado Medical Society in legislative matters.

K. Mason Howard, MD

In a year which has represented severe change in the services and organization of the Colorado Medical Society, as well as in the practice of medicine, Dr. K. Mason Howard has served his fellow professionals with candor, continued good spirit and perseverance.

Dr. Howard is recognized for his

abilities to formulate, negotiate and administer the needs of such a professional organization, while upholding the finest image of his fellow physicians. His outstanding service and leadership has resulted in accomplishments which will be long remembered by the membership. He has sown the seeds of reorganization which will flourish for many years in the growth of the Colorado Medical Society.

Robins Award Physician Award for Community Service

Presented by

The Colorado Medical Society

111th Annual Meeting

September 8-12, 1981

As is the custom each year at its Annual Session of the House of Delegates, the Colorado Medical Society Awards Committee chooses one physician for his outstanding community service during the past year.

For the first time in its 111 year history, the Colorado Medical Society Awards Committee this year elected to present the A. H. Robins Award to a non-member physician, recognizing his special services to the community in which he lived and practiced. The award this year is presented, posthumously, to Roger Hamstra, M.D., a member of the Department of Medicine, University of Colorado School of Medicine.

Dr. Hamstra has been recognized by his fellow physicians for his continued services to medical and health education, particularly through his work with the Colorado and Denver Medical Society in producing and hosting the outstanding monthly television program, "Medicaline." Dr. Hamstra's efforts in public and community service were not limited to this one exposure. Roger Hamstra was well known and highly respected in his private life because of his devotion to his family and friends, his work with young people in social, moral, health and religious education, and his willingness to be of help to others around him in many community roles.

Though he was not a member of Colorado or Denver Medical Society, it was the feeling of all who knew him that Roger Hamstra was a fellow.

Because of his specific teaching role, Dr. Hamstra did not feel the need for membership in the professional association, but this did not prevent him

(Continued on next page.)

Symposium Announced

The Colorado Medical Society and The Rocky Mountain Drug Consultation Center announce their joint sponsorship of the program, *Practical Therapeutics for Physicians: 1981*. This one-day symposium is directed at providing the physician with the most up-to-date information regarding commonly encountered therapeutic problems and will discuss recent advances in drug therapy.

Highlights include *Antibiotic Therapy* by John Mills, MD (Chief of Infectious Disease, San Francisco General Hospital), and *Antiarrhythmic Drug Therapy* by Alan Nies, MD (Head of Division of Clinical Pharmacology and Toxicology, University of Colorado Health Sciences Center). Other topics include:

- Drugs in Pregnancy and the Breast-Feeding Period
- Management of Severe Hypertension
- Critical Appraisal of New Drugs
- Use of Non-FDA Approved Drugs
- Drug Withdrawal Symptoms

Approval has been awarded for 7.0 hours of Category 1 credit for the Physician's Recognition Award of the American Medical Association of the Denver Department of Health and Hospitals/Colorado Medical Society approved CME program.

For more information, contact Mrs. Beth Pillar at the Rocky Mountain Drug Consultation Center at 893-DRUG or toll-free in Colorado at 1-800-332-6475.

(Continued from previous page.)

from giving of a great deal of time and energy to the support of the goals of organized medicine. He worked hand in glove with members and staff of Colorado and Denver Medical Societies to develop, perpetuate and continually improve the public knowledge of the practice of medicine. For his efforts, the television program "Medicaline" was twice recognized and received distinguished awards on each occasion.

It is with a deep feeling of appreciation that the President of Colorado Medical Society joins the A. H. Robins Company in presenting to Mrs. Roger Hamstra the Robins Award, in honor of her late husband.

How Do I Limit My Malpractice Premiums?

From Physicians of the Professional Liability Trust

New York State is now struggling with a tough issue of increased premiums leading to a malpractice crisis of horrendous proportions, endangering the health care system in that state. Will our state be next? Yes, unless we do something now!

The difference between Colorado's situation and New York's goes beyond just geographic. Our current united stand of 3,600 physicians has enabled our risk management team of Bob Brittain's M.L.C.P. to be viewed nationally as a model program. This program is constantly working at maintaining and increasing risk management, especially through its exceptional educational programs.

Secondly, our physicians are represented by some of the most outstanding and highly expert legal counsel in the United States in all matters of claims and defense. The firm of Johnson, Mahoney & Scott's reputation of nonsettlement has greatly reduced the amount of claims against Colorado physicians.

If this united position does not continue, potentially Hartford and

other insurers may openly compete in the market with no guarantees of quality of risk management and defense. Such competition may also decrease the percentage of premium dollars spent on these two important programs, therefore reducing their effectiveness.

Should these events actually happen, it is projected that the loss of effective risk management and defense can only result in the generation of more claims and higher premiums. We could find ourselves in a malpractice "crisis" as now seen in New York State with physicians seeing their malpractice premiums quadruple!

What can we do? We must keep the united stand in Colorado by participation in the Colorado Medical Society Professional Liability Trust. We can then begin to assume control of the entire malpractice insurance program in Colorado. The long-term benefit of premium stability can be achieved by minimizing administrative costs, rate-making based entirely on Colorado experience, and retention of the best risk management team and defense counsel available.

Now is the time for all CMS physicians to participate in the Trust at no additional cost or risk, so that we may continue our progress toward the best possible long-term solutions to malpractice insurance in Colorado. The Trust is now a real entity with membership firming up. We must keep the momentum going.

Dr. Haley Retires from Practice

"I've delivered a lot...yes, a lot of babies! And I love surgery!" Those were the words of Longmont, Colorado GP James S. Haley, MD, upon announcing his retirement from practice, after 41 years. Haley said in July that he was retiring "with mixed feelings." He added that his philosophy has been to personalize his patient-doctor relationship so that "you get to know...and like your patients. As a result," Haley said, "it is difficult to know how to

answer them when they ask 'What am I going to do without you?' or 'What doctor do you recommend?'"

The person who has closely shared all of his experience has been Dr. David McCarty, who has worked with Dr. Haley during the entire 41 years in Longmont practice. Dr. McCarty said "Through it all, we never one time had any dissention. We practiced so much alike that we could use each other's medical bags." McCarty added: "I've never heard him [Haley] make a disparaging remark about anyone."

Dr. Haley was born on August 17, 1909, in Paonia, Colorado. His father was a doctor, so the course he would follow seemed natural, but not without some detours in the program. Haley first wanted to follow his boyhood inclinations of becoming an athletic coach. He had excelled in sports, lettering in football, basketball, track and baseball during high school, so he went to CU at Boulder to become a coach. The school wasn't all that easy to enter: the applicants had to have two years of one language for admission. The alternative was to enter "engine" school. Instead, Haley went back and took another year of high school French and helped with coaching. He was admitted to CU in 1928 and gained admission, fast becoming a standout in football, baseball and track. Sports writers used all sorts of adjectives to describe his athletic prowess. When "prowess" is used to describe John Haley, here's why: he won three letters in football, three in basketball, two in track and two in baseball for an historic ten letters. He was also All Conference in football in 1931.

After graduation in education he went to Lamar (Colorado) high school as a coach, but things at the time (depression years) were very unstable, so it was then he decided "that was no place for me; I'd better get into medicine." He graduated from CU Medical School in 1938, and interned at Denver General Hospital for 18 months, entering medical practice in Paonia with his father in 1939.

Concerning his life, in general, Dr. Haley says "I've been so gosh darned lucky with everything I wouldn't change anything if I had it to do over. I've been very fortunate."

Professional Education Update

The Diagnosis and Management of Common Skin Cancers. Stephen L. Gumpert, MD, et al. Skin cancer, the cancer of highest incidence, may at times be prevented for it can be caused by exposure to environmental carcinogens such as sunlight, x-rays, and chemicals. When it does occur, skin cancer offers a unique opportunity for early diagnosis, treatment, and cure because of its direct visibility and easy accessibility.

In this article, Drs. Gumpert, Harris, Roses and Kopf discuss the three most common types of skin cancer—basal cell carcinoma, squamous cell carcinoma, and malignant melanoma—detailing the clinical characteristics of each. Also discussed are procedures for a proper and thorough examination, indications for biopsy, danger signals that suggest malignant transformation in pigmented nevi, and the treatments of choice. Color photographs of typical malignant lesions are included.

What is the Best Test to Detect Prostate Cancer? Patrick Guinan, MD, et al. Dr. Guinan and coauthors have evaluated 10 screening tests used to detect prostate cancer, and they report their methods and results in this new Professional Education Publication.

After analyzing each test for sensitivity, specificity, and efficiency, the authors conclude that the diagnostic accuracy of the digital rectal examination is "unexcelled by more recent, complex, and expensive tests."

Booklet Available to Physicians

Available from the Colorado Medical Society's Medical Affairs Division are copies of the "Guide for Interprofessional Relations." This booklet contains the Interprofessional Code and the Joint Medico-Legal Plan for Screening Professional Liability Cases, as published by the Colorado Bar Association and the Colorado Medical Society. Any physician who would like a copy of

the Guide may call the office of CMS, 861-1221, ext 232, or stop by the office at 1601 E. 19th Avenue, Denver.

Social Security Announcement

The Colorado Social Security Disability Determination Services is pleased to announce the appointment of James Day, MD, as Chief Medical Consultant for the agency. Dr. Day can be reached on Monday and Tuesday mornings and on Thursday and Friday in the afternoon at 758-5539.

Montrose Physicians Establish Scholarship Program in Honor of Dr. George Balderston.

The Curecanti Medical Society has given three \$1,000 scholarships to Montrose women in the medical profession. The scholarships were in honor of the late Dr. George Balderston, who passed away two years ago. The Balderston Memorial Scholarship program was established by the Curecanti Medical Society as an annual award, however, this year the Montrose members of the Society volunteered \$1,000 to be given to:

Sandra Jordan, a nurse aide at the Colorow Care Center in Olathe. She has been accepted for the LPN program at the Delta-Montrose Vo-Tech School.

Two more scholarships of \$1,000 each, made possible by Dr. Balderston's wife, Jean, went to Carol Bishop, laboratory aide, emergency room assistant and LPN at the Montrose Memorial Hospital (she will attend the RN program at Mesa College this fall), and Kris Natzke, a respiratory therapist at Montrose Memorial Hospital, who has entered RN training at Mesa College.

Upon completion of their training, all three recipients will return to Montrose to continue in their new specialty fields. The scholarship program is open to any persons wishing to pursue training in a health related field.

"Best Doctors" List Includes 16 CMS Members

Author John Pekkanen's latest edition of "The Best Doctors in the U.S." contains a list of more than 3,000 physicians who are considered by their peers to be the "best" in one of 45 medical specialties in the country. Of the total there are 33 in practice in the Denver area, 16 of whom are members of the Denver and Colorado Medical Societies.

Pekkanen interviewed more than 1,000 of the leading physicians in the country, asking them to list those doctors they considered were practicing a specialty in a way that is considered superb. Pekkanen also asked his interviewees to nominate physicians who were known to be sympathetic to their patients and able to establish a rapport with the patient. Physicians listed in the book who are also members of Denver and Colorado Medical Societies are:

Richard Hamilton and Herbert J. Rothenberg, internists;

Thomas L. Petty, lung specialist

Stuart Schneck, nervous system;

W. Bruce Wilson, specializing in diseases of the eye;

Eugene Wiggs and Lemuel T. Moorman, ophthalmologist;

Mack L. Clayton and Robert Eilert, orthopedic surgeon;

Loren Goltz, dermatologist;

David S. Pearlman, allergist;

Michael L. Johnson, diagnostic radiologist;

Kenneth Gottesfeld and Stuart Gottesfeld, obstetricians;

Arnold Silverman and William Schneider, pediatricians.

The book lists 33 Denver area doctors in all, all of them professors or associate professors at the University of Colorado Health Sciences Center.

Open Invitation to Physician Artists

Many physicians throughout history have been involved in creative hobbies, such as painting, sculpturing.
(Continued on next page.)

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ing, photography, and crafts. However, in the United States it was not until 1936 that they had an organization in which they could exhibit these creative ventures. At that time the American Physicians Art Association was organized by the late Frances H. Redewill, Sr., MD, a San Francisco urologist and a talented marine painter. He and some other physician artists had the first exhibition of APAA at the convention of the American Medical Association in San Francisco in 1936.

The majority of members of the APAA are active, artistic creators who exhibit their work in one or more of the following categories: Oils and Acrylics, Watercolors, Sculpture, Photography, Arts and Crafts, and/or Graphics and Miscellaneous.

This year the APAA Annual Art Exhibition and annual meeting will be held during the 75th annual Southern Medical Association meeting in New Orleans, Louisiana, November 15-18. Membership in the Southern Medical Association, however, is not required.

Membership is open to all physicians. Those interested should write to: Milton S. Good, M.D., Treasurer, APAA, 610 Highlawn Avenue, Elizabethtown, PA 17022.

Help Available for Impaired Physicians

CMS has an impaired physician program to help physicians before they endanger their patients or themselves.

A few years ago the CMS Board of Directors received a charge from the House of Delegates to create a program designed to aid impaired physicians—to help them confront their problems and find treatment. The Physician Health and Rehabilitation Committee works as an advocate—not in a punitive manner.

Those who know of a colleague who may have a problem, or who need help themselves, should contact the Committee at the CMS office in Denver, 861-1221.

Delegate Attendance 1981 Annual Meeting

District 1: 18 Delegates

Larimer: 8 Delegates

- (D) Baumgartel, Earl D. (1-2)
- (D) Bruns, Thomas N.D. (1-2)
- (D) Merkel, Lawrence A. (1-2)
- (D) Codd, Richard L. (1)
- (D) Cronin, John C. (1-2)
- (D) Miller, Burdette L. (1-2)
- (D) Pashkow, Fredric J. (1-2)
- (D) Standard, Peter J. (1-2)

Morgan: 1 Delegate

- (D) Thompson, Patrick L. (1-2)

Northeast Colorado: 1 Delegate

- (D) Ezell, William W. (1-2)

Washington-Yuma: 1 Delegate

None Present

Weld: 6 Delegates

- (D) Bagley, David L. (1-2)
- (D) Baldwin, Thomas E. (1-2)
- (D) Foulk, Arnold R. (1-2)
- (D) Cash, Robert L. (1-2)
- (D) Hartley, Robert D. (1-2)
- (A) Wikholm, Larry J. (1-2)

District II: 120 Delegates

Adams County-Aurora:

8 Delegates

- (A) Hopple, Lynwood M. (1-2)
- (D) Heaton, C. Edward (1-2)
- (D) MacPhee, William M. (2)
- (D) Kitlowski, Noel P. (2)
- (A) O'Dell, Robert A. (1-2)
- (A) Canham, Douglas (1)*
- (A) Greenholz, Daniel J. (2)*
- (D) Martin, William J. (1-2)

Arapahoe: 14 Delegates

- (D) Carver, Robert K. (1-2)
- (A) Barte, Roy M. (1-2)
- (A) Ochsner, Ronald C. (1)
- (D) Miller, Meredith H. (1-2)
- (D) Milligan, Gatewood C. (1-2)
- (D) Sargent, Frank T. (1-2)
- (D) Spalter, Roger M. (1)
- (A) Bigelow, Eugene V. (1)
- (A) Steines, William J. (2)
- (A) McQuaid, James L. (1)

- (A) Bartlett, Max D. (1-2)
- (D) Thompson, Richard H. (1-2)
- (D) Wood, John M. (1)
- (D) Seegers, Winnifred (2)

Boulder: 11 Delegates

- (D) Baumgardner, Jan E. (1-2)
- (A) Firestone, Marvin (2)*
- (A) Fitzgerald, David (1)*
- (D) Kelley, Severance B. (1-2)
- (D) Smith, Darwin W. (1-2)
- (D) Stormo, Alan (1-2)
- (A) Freudenberg, James (1-2)
- (D) Cletcher, John O. (1-2)
- (D) Rubright, Mark W. (1-2)
- (D) Stein, Donald W. (1-2)
- (D) Wilson, Don E. (1-2)

Clear Creek Valley: 20 Delegates

- (D) Brundige, Richard (1-2)
- (D) Call, William H. (1-2)
- (D) Cedars, Chester M. (1-2)
- (D) Ford, John J., III (1-2)
- (D) Henderson, Kenneth R. (1)
- (A) Collier, Robert (2)
- (D) Markel, William R. (1-2)
- (D) Oppenheim, Walter H. (1-2)
- (D) Silverberg, Stuart O. (1-2)
- (D) Stevens, Wayne E. (1-2)
- (D) Weston, Eugene L. (1-2)
- (D) Campbell, Bernard E. (1-2)
- (D) Doig, William L. (1-2)
- (D) Golbert, Thomas M. (1-2)
- (D) Mann, James (1-2)
- (D) McCreedy, Gordon J. (1-2)
- (D) Ritzman, Vernon D. (1-2)
- (D) Sadler, Dean L. (1-2)
- (D) Tegmeier, Ronald (1-2)
- (D) Whitesel, John (1-2)
- (D) Yakely, M. Robert (1-2)

Denver: 64 Delegates

- (D) Bosworth, Robert G., Jr. (1)
- (D) Brock, L. Loring, Jr. (1)
- (D) Butterfield, Donald G. (1-2)
- (D) Craigmile, Thomas J. (1)
- (D) Cundy, Richard L. (2)
- (D) Defoe, Charles A. (1-2)
- (D) DeLauro, John E. (1-2)
- (D) Elliott, Robert V. (1-2)
- (D) Flax, Leo J. (1-2)
- (A) Howe, Patrick A. (1-2)
- (D) Galloway, W. Ben (1-2)
- (A) Bennett, Willis (1-2)
- (D) Inkret, William, Jr. (1-2)
- (D) Livingston, Wallace H. (1-2)
- (D) Mutz, Austin E. (1-2)
- (D) Nelson, J. Phillip (1-2)
- (D) Sawyer, Robert B. (1-2)
- (D) Schemmel, Janet E. (1)
- (D) Aikawa, Jerry K. (1-2)

(A) Safford, H. Robert, III (1-2)*
 (D) Butterfield, L. Joseph (1)
 (D) Campbell, William A., III (1)
 (D) Cook, William R. (1-2)
 (A) Cochrane, David R. (1-2)
 (D) Humphries, Jesse H. (1-2)
 (D) Jennings, R. Lee (1-2)
 (D) Kennedy, Timothy C. (1)
 (D) Kovarik, Joseph L. (1-2)
 (D) Miller, Edward S. (1-2)
 (D) Nelson, Nancy E. (1-2)
 (D) Parsons, Donald W. (1-2)
 (D) Peck, Mordant E. (2)
 (D) Reimers, Wilbur L. (1-2)
 (D) Mowry, Norman C. (1-2)
 (A) Newman, Thomas H. (1-2)
 (D) Sides, LeRoy J. (1-2)
 (A) Oliphant, M.M., Jr. (1-2)
 (D) Sullivan, Robert C. (1-2)
 (D) Toll, Giles D. (1-2)
 (D) Toll, Henry W., Jr. (2)
 (A) Waldman, Lawrence (1-2)

University of Colorado Medical Students: 3 Delegates

(D) Starkebaum, Mark A. (2)
 (A) Minton, Douglas (1-2)*
 (D) Kucera, John L. (2)

District III: 18 Delegates

Eastern Colorado: 1 Delegate

(D) Keefe, Jerome L. (2)

El Paso: 15 Delegates

(D) Crawford, Lewis A. (1-2)
 (D) Dawson, Dwight C. (1-2)
 (D) Lloyd, William E. (1-2)
 (A) Gazibara, Donald P. (1-2)
 (D) Martin, Alfred J., Jr. (2)
 (D) Pollard, Joseph S., Jr. (1-2)
 (D) Baron, J. Gregory (1-2)
 (D) Cooper, Jack (1-2)
 (A) Baker, Robert (1-2)
 (D) Hanson, J.R. (1-2)
 (D) Kandel, George E. (1-2)
 (D) Marta, John A. (1-2)
 (D) Martz, David C. (1-2)
 (D) McMullen, R. Bard (1-2)

Intermountain: 1 Delegate

None Present

Lake: 1 Delegate

None Present

District IV: 18 Delegates

Chaffee: 1 Delegate

(A) Loeffel, Edwin (1)*

Fremont: 2 Delegates

(D) Vincent, Jack (1-2)
 (D) Greenlee, Lynn (2)

Huerfano: 1 Delegate

None Present

Las Animas: 1 Delegate

(D) Jimenez, Guilebaldo E. (1-2)

Otero: 2 Delegates

(D) Knaus, Kendal C. (1-2)
 (D) Baumgartner, Robert B. (1-2)

Pueblo: 8 Delegates

(D) Dingle, Robert W. (1-2)
 (D) Courtright, C.L. (1-2)
 (D) Lenz, Theodore R. (1-2)
 (D) Smith, Harold J. (1)
 (D) Boucher, Wesley W. (1)
 (D) Crosson, David L. (1-2)
 (A) Eifert, Earl D. (1-2)
 (D) Phelps, Harvey W. (1)

San Luis Valley- 2 Delegates

None Present

Southeastern Colorado: 1 Delegate

(D) Krausnick, Keith F. (1-2)

District V: 218 Delegates

Delta: 1 Delegate

(D) Bennett, Robert, Jr. (1-2)

La Plata: 3 Delegates

(D) Buslee, Roger M. (1-2)
 (D) Davis, Telford A. (1-2)

Mesa: 6 Delegates

(D) Huskey, Harlan (1-2)
 (D) Painter, M. Ray (1)
 (D) Hartshorn, Denzel (1-2)
 (D) Moran, Patrick (1-2)
 (D) Nelson, Kenneth E. (1-2)
 (A) Scott, William (2)*

Monteletes: 1 Delegate

(A) Heyl, Robert A. (1)

Curecanti: 2 Delegates

(D) Canfield, Thomas M. (1)

Mount Sopris: 3 Delegates

None Present

Northwestern Colorado:

2 Delegates

(A) France, David (1-2)*

* Substitute Alternate appointed to fill a vacant seat

1 - Attended first meeting of the House of Delegates

2 - Attended second meeting of the House of Delegates

New Poetry Contest

A \$1,000 grand prize will be awarded in the upcoming poetry competition sponsored by World of Poetry, a quarterly newsletter for poets.

Poems of all styles and on any subject are eligible to compete for the grand prize or for 99 other cash or merchandise awards, totaling over \$10,000.

Says Contest Chairman Joseph Mellon, "We are encouraging poetic talent of every kind, and expect our contest to produce exciting discoveries."

Rules and official entry forms are available from the World of Poetry, 2431 Stockton Blvd., Dept. D., Sacramento, California 95817.

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Colorado Foundation For Medical Care Develops Policy on Plasmapheresis

(Report written for and approved by the Health Care Standards Committee, 8/18/91)

The Colorado Foundation for Medical Care was asked by local physicians and by Blue Cross/Blue Shield of Colorado to address the use of plasmapheresis ("plasma exchange") as a treatment methodology for a variety of conditions. A subcommittee of the Foundation's Health Care Standards Committee chaired by Robert V. Elliott, MD, and comprised of Steven Ringle, MD, (neurologist), Robert Chapman, MD, (hematologist), Herbert Kaplan, MD, (rheumatologist), Peter Kohler, MD, (immunologist) and Alan Alfrey, MD, (nephrologist), met to discuss this issue. After a review of the literature available on plasmapheresis and discussion of local practice patterns, the subcommittee developed the following statement which was subsequently approved by the Foundation's Health Care Standards Committee and the Colorado Foundation for Medical Care's Board of Directors:

Policy Statement on Plasmapheresis

Plasmapheresis is an expensive, time-consuming therapy with potential risk and uncertain effectiveness which at present should be conducted only under carefully defined conditions. Responsible physicians administering this form of treatment

must have expertise in the diagnosis and total management of the diseases being treated as well as the technical aspects of plasmapheresis. At this time plasmapheresis should only be performed in an appropriate setting with facilities and expertise to deal with complications of plasma exchange. Because of the generally experimental nature of treatment with plasmapheresis at this time there are two general guidelines that should be applied to any contemplated use of the treatment. They are:

1. Plasmapheresis should be used only after conventional forms of treatment have been tried and have proved ineffective, and
2. Plasmapheresis should only be used as treatment in life threatening situations for specific conditions as outlined below. (In some life threatening situations it may not be possible to have used conventional forms of treatment prior to the use of plasmapheresis. In these cases, conventional forms of treatment may be used in conjunction with plasmapheresis.)

The use of plasmapheresis in the treatment of the following conditions is considered appropriate at this time. After ten exchanges, however, each case should be reviewed by a panel of plasmapheresis experts to determine whether the treatment continues to be appropriate for the particular patient. The conditions which are considered to be appropriate are:

1. Myasthenia gravis during a life threatening crisis,
2. Anti-basement membrane antibody nephritis (i.e., as a result of

- Goodpasture's Syndrome),
3. Life threatening immune complex vasculitis,
4. Hyperviscosity of the blood associated with multiple myeloma, Waldenstrom's macroglobulinemia, and hypergammaglobulinemia purpura,
5. Thrombotic thrombocytopenic purpura.

Research results available at this time indicate that patients receiving plasmapheresis as treatment for immunologic diseases should receive concomitant immunosuppressive therapy.

It should be made clear to patients and physicians that these cases are still subject to review by the proposed plasmapheresis panel, and that such a review on a case-by-case basis may result in retrospective denial of payment.

The use of plasmapheresis for treatment of other than the conditions listed above is to be considered experimental. As such, any such treatment should be authorized prior to treatment by the plasmapheresis panel on a case-by-case basis to determine appropriateness and evolving state of the art. Every effort should be made in these experimental applications to collect data before and after treatment which will be indicative of the treatment's effectiveness. Ideally, such treatment should only take place using scientific methodology incorporating a control group. Examples of experimental applications are the use of plasmapheresis in treatment of rheumatoid arthritis, systemic lupus erythematosus, multiple sclerosis, polymyositis, pemphigus vulgaris, and chronic lymphocytic leukemia.

Medical Society Long-Range Plan Emphasizes Medical School Relationships

The CMS House of Delegates, at its 1981 Annual Session, approved a long-range educational plan developed by the Council on Professional Education. The plan is a blueprint for program activities by the Medical Society for the next five years. It provides that the Medical Society shall give special emphasis to developing close working relationships on educational matters with the University of Colorado School of Medicine. A special sub-committee of the Council will work with the UCSM Committee on Curriculum on the process of developing curriculum modifications. Cooperative working relationships will also be maintained with the UCSM Office of Post-Graduate Education and the Office of Educational Services.

Other features of the long-range educational plan envision an array of educational support services for physicians and for continuing medical education programs. These services will include consulting and advising, a wide array of informational services, including newsletter, handbooks concerning methods of education and assistance for physicians in preparing professional articles for publication. Support services will also include research services such as examinations of improved methods for evaluating CME. The Society will also sponsor educational conferences, e.g., Congress on Continuing Medical Education for Colorado and intermountain continuing medical educators, featuring speakers of national reputation.

The Society will also serve CME in Colorado by maintaining its program of accreditation for CME programs in hospitals and medical specialty societies.

The second major objective of the long-range plan is to provide direct educational programs for physicians on clinical and non-clinical topics. Non-clinical subjects may include liberal education for physicians, practice management, medical economics, and medical political issues. Clinical presentations will be

clustered around the CMS Annual Meeting and special clinical presentations may be provided for physicians according to need.

The long-range plan also provides that the CMS staff and membership will maintain liaison with national, state and local organizations that are concerned with continuing medical education.

Copies of the CMS long-range educational plan will be supplied on request. Write the Colorado Medical Society, Division of Continuing Education, 1601 E. 19th Avenue, Denver, CO 80218, or phone (303) 861-1221, ext. 262.

Highlights of Meeting of the Committee on Accreditation, Sept. 24, 1981

At its meeting on September 24th, the Colorado Medical Society's Committee on Accreditation acted on several institutions which had been site surveyed for new accreditation or re-accreditation. The Colorado Society for Clinical Neurologists and Mercy Medical Center, Denver, were approved for full accreditation. Denver General Hospital and Parkview Episcopal Hospital, Pueblo, also had their accreditation extended. Southwest Memorial Hospital, Cortez, was accredited for the first time.

Southwest Memorial Hospital/Montezuma County Hospital District is a 60-bed hospital and nursing home which has been offering CME programs for only three years. In May, 1979, the hospital made an initial inquiry concerning accredita-

tion. In February, 1981, Kevin Bunnell, Director of the Division of Continuing Education, met with the active physician staff and administration of the hospital to explain what they needed to do to meet the Essentials for Accreditation. Only six months later Southwest Memorial Hospital was site-surveyed and approved.

Teleconferencing II Begun in October

Because of the positive response to a survey sent out to participants in the Teleconferencing I series, another series of CME telecommunications programs was begun in October.

These one-hour accredited CME programs will take place on the third Friday of each month, October, 1981, through April, 1982, at 7:30 p.m.

The first presentation was "What We Know About Allergies That's Useful." The presenter was Henry Claman, MD. The second program, "A Rationale for the Selection of Antibiotics," on November 20th, will be presented by Steven Mostow, MD.

The programs are presented by a two-way amplified telephone system called Tele-Net, and sponsored by the Colorado Medical Society and the University of Colorado School of Medicine.

The goals of the project are to provide high quality CME for medical staffs in community hospitals and to expand the understanding of the use of telecommunications in continuing medical education.

The AMA-Washington Office: What It Does and How It Functions

The Washington Office works as a highly specialized group of experts who serve as the extended arm of the AMA in Chicago. Efforts to increase the effectiveness of the Washington Office are always made.

The Washington Office is a unit of the Division of Public Affairs, linked so closely with Chicago with tielines, teletype, and thermofax that contact is continuous throughout the working day, and often goes on well after the day has ended.

Under the Washington Office Director and his deputy are four office departments: Congressional Relations, Federal Affairs, Communications and the library. Each unit is an integral part of an apparatus which serves one overall function—the representation of American physicians in the federal government process.

A Director and four Assistant Directors comprise the Department of Congressional Relations. All have Capitol Hill experience and combine a thorough knowledge of the legislative process with a wide network of Congressional contacts. They cover all 535 members of Congress and their staffs, and work intensively with the staffs and Members of those key committees through which the bulk of important health legislation must pass. Each member of this department also maintains contact with a large number of organizations having interests in health legislation.

The Deputy Director of the Washington Office is also Director of the Department of Federal Affairs

which works closely with the White House and other agencies of the Government. Two members of the Departmental staff, the Associate Director and the Assistant Director, have primary responsibility for maintaining ongoing liaison with two components of HEW, the Public Health Service (and its six major agencies) and the Health Care Financing Administration (Medicaid and Medicare), respectively. The major functions of the Department are to urge the federal agencies to accept the Association policy positions in the administration for their

health programs and to report on new federal proposals of a regulatory or legislative nature.

Within the department are also two legislative attorneys who research major federal legislation affecting health, attend hearings, monitor the Congressional Record and the Federal Register, work with the Division's Legislative Department in Chicago, confer frequently with lobbyists, and staff all meetings of the AMA's Council on Legislation.

While the staff of the Department of Congressional Relations has specific assignments to provide information to the state medical societies, the two legislative attorneys in the Department of Federal Affairs are responsible for maintaining working relationships with the medical specialty societies. Both departments supply legislative or regulatory materials and information to their assigned groups. All members of the Washington Office staff are available at all times for specialized requests for the state and specialty societies.

The four-man Communications Department deals with all media, covers the Washington scene for



Rehabilitation Groups of the American Cancer Society

Reach to Recovery

Reach to Recovery is a rehabilitation program for women who have had breast surgery. It is designed to help them meet their physical, psychological, and cosmetic needs. Volunteers, who have been selected by their doctors and have completed training, visit patients in the hospital with the physician's approval. No medical advice is given but compassion and emotional support are available.

For more information,

American Cancer Society
Colorado Division, Inc.
321-2464

AMA News and JAMA, and helps Congressional staffs with research or speech material. The Department makes regular contact with members of the Washington communications community.

Supporting these activities with a broad array of background information and material is the library, which serves office staff, medical societies, the general public, Congress, and the federal agencies.

How does this administrative unit work to reflect AMA policy? First, the AMA's legislative objectives are set by its House of Delegates, usually on broad policy guidelines, for use by the AMA's Council on Legislation when the time comes to review the many varied issues developing in government. One of the Council's seven meetings each year is devoted to the interests of the specialty societies, and representatives of the societies are invited to participate with the Council in its deliberations. Another meeting is open to all constituent societies and members. The Council recommends to the Board of Trustees that positions on legislative and administrative proposals are adopted. Once the Board

has acted, its decisions are sent to the Public Affairs Division for appropriate implementation in Chicago and Washington.

practicing physicians' viewpoints and supporting arguments are made known

As part of the Public Affairs Division, Washington Office staff members articulate the interests of all segments of organized medicine, including the special expertise and interests of the state and medical specialty societies. The legislative attorney and members of the Congressional Relations Department assist in staffing all meetings of the AMA Council on Legislation as advisors.

The Washington Office hosts legislative briefing sessions for state medical societies, specialty societies, civic and educational groups. The specialty society briefings are held every 8 weeks, with both Washing-

ton and Chicago AMA staff members participating. Each state society briefing is tailored to the specific needs (and requests) of the particular society. Extensive background material is prepared for briefings, and mutually beneficial discussions of legislative and administrative issues are fostered.

It is through the AMA Washington Office that practicing physicians' viewpoints and supporting arguments are made known to the legislative and executive branches of government. By and large, this method has proved effective. The Congress usually welcomes AMA viewpoints because it recognizes that the public cannot be well served unless all portions of a question are carefully weighed. Thus, such independent forces as organized medicine contribute to the public weal by studying and questioning what government does, should not do, does not do, and should do.

In summation, the AMA-Washington Office is a crucial, integral component of a complex mechanism designed to convey the individual American physician's viewpoint to the federal government.

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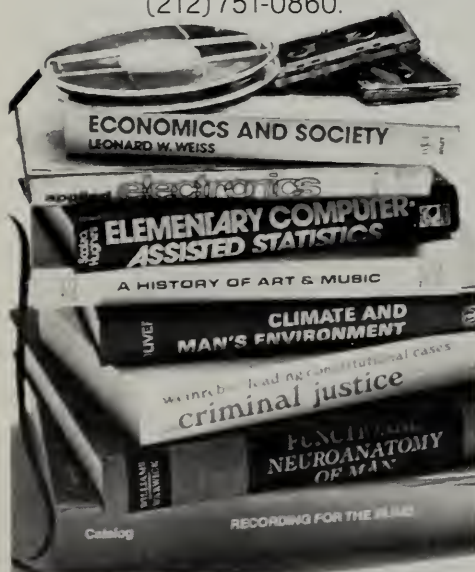
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COMPAC Report

By H. R. Safford, III, MD,
Chairman,
CMS COMPAC Committee

As Chairman of the Colorado Medical Political Action Committee (COMPAC), I was privileged to attend the American Medical Political Action Committee (AMPAC) Political Education Conference in Washington, D.C., September 16 through the 18th.

Washington is an awesome city. It is the hub of decision making and policy setting for the entire United States. One can feel the raw political power that is present everywhere.

The same excitement and power was felt September 16th when AMPAC hosted a reception of the 97th Congress. Most states had excellent congressional representation *with the exception of Colorado. No Colorado Congressman or staff person was present.* This only means to me that we need to increase the size of COMPAC in order to strengthen our political power base.

Over 400 physicians and medical society and PAC staff members attended the various workshops. The opening workshop was on "Political Perspectives" by David Broder, Pulitzer Prize-winning political columnist. He felt Ronald Reagan and the Republican Party won "big" in 1980 for four reasons:

1. Inflation;
2. Loss of world leadership position;
2. Rise of social conservatism;
4. Collusion between the Republican Party, its congressional candidates and Ronald Reagan supporters.

The next and perhaps most exciting workshop was on Independent Expenditures (I.E.). In 1976 the Supreme Court ruled that the FEC laws on limited expenditures for congressional campaigns was a violation of the first constitutional

amendment. As such, any individual organization may spend an unlimited amount of dollars to support a congressional campaign, provided the candidate and his staff has no prior knowledge of that expenditure.

I was incredibly impressed with the political sophistication of AMPAC. With conservative astuteness, they supported (bi-partisanly) seven congressional campaigns with direct mails and succeeded in five of the seven. Using TV spot films, they were successful in six of seven races. That is an outstanding record and showed the effectiveness of the independent expenditures.

The next most stimulating workshop was on increasing PAC membership. Pennsylvania PAC made an excellent audio-visual presentation designed for physician education on a hospital staff and county medical society level. The Ohio PAC presented a program for well-timed sequence of letter solicitations. Both of these are available to COMPAC for incorporation into our membership drive efforts.

Recruiting and evaluation of congressional candidates provided an in-depth insight into who makes a good, successful candidate. This will also be useful in deciding which state candidates should be supported by COMPAC in their campaign efforts.

There were additional workshops updating FEC campaign laws, organizing campaign volunteers and fundraising for candidates, campaign headquarters management and voluntary recruitment, and lastly, conducting voter registration and "get out the vote" drives.

Representative Tony Coelho of California, who is chairman of the Democratic Congressional Campaign Committee, clearly explained the revamping of the Democratic campaign effort and astutely outlined the party's approach to the 1982 campaign.

Socially, the conference was highlighted with the black tie AMPAC 20th Anniversary banquet and gala ball. It was a rare opportunity to associate with the leaders in the AMA and state PAC movements.

Overall, the meeting was politically stimulating and a great learning experience.

Cancer Incidence in an Area Contaminated with Radionuclides Near a Nuclear Installation

Report

By Carl J Johnson, 42 Hillside Drive,
Denver, Colorado 80215, USA

Anglo cancer incidence for the period 1969–1971 was evaluated in census tracts with and without contamination by plutonium and other radionuclides from the Rocky Flats (nuclear weapons) plant near Denver, Colorado (1970 population 1 019 130). Exposures of a large population in the Denver area to plutonium and other radionuclides in the exhaust plumes from the plant date back to 1953. Cancer incidence in males was 24 percent higher, and in females, 10 percent higher in the most contaminated suburban area (population 154 170) (nearest the plant), compared to the unexposed area (population 423 870), also predominantly suburban, which had virtually the same age-adjusted rate for all cancer as the state. The adjacent study area more distant from the plant had an excess cancer incidence of 15 percent in males. The excess cases of cancer were mostly leukemia, lymphoma and myeloma and cancer of the lung, thyroid, breast, esophagus, stomach and colon, a pattern similar to that observed in the survivors of Hiroshima and Nagasaki. The ratio of cancer of the more radiosensitive organs to other classes of cancer was 12.2 percent higher in the area near the plant (17.6 percent in males, 11.9 percent in females). These ratios were not significantly changed with the deletion of lung cancer. Cancer of the gonads (especially of the testes), liver, and, in females, pancreas and brain contributed to the higher incidence of all cancer in areas near the plant. The increase in incidence of all cancer and for certain classes of cancer in the exposed population supports the hypothesis that exposure of general populations to small concentrations of plutonium and other radionuclides may have an effect on cancer incidence.

EDITOR'S NOTE: This article, a reprint from the 1981 edition of AMBIO, A Journal of the Human Environment, Published by the Royal Swedish Academy of Sciences.

Carl J. Johnson, MD, of Denver, Colorado, is a member of the Colorado Medical Society and former director of the Jefferson County Department of Health. He has been the center of considerable controversy because of his studies and reports of plutonium contamination in the soils located downwind of the Rocky Flats Nuclear Weapons Plant.

In 1980, COLORADO MEDICINE invited both Dr. Johnson and other physicians to comment on the hazards of low-level ionizing radiation in relation to the Rocky Flats plant. At the same time, the editors and publishers invited members of the Rockwell International plant management to submit for publication their findings on the same and related subject research.

As a result of this broad invitation, seven articles, prepared by the experts of Rockwell International, reporting on their own radiation and environmental investigations, were published in total and unedited by the editors or publishers of this magazine.

Dr. Johnson was then invited to respond to the articles by Rocky Flats experts, and elected to have this reprint of his recent article in AMBIO. We do so here, hopefully to present at least two principal sides of the on-going investigation and controversy.

A nuclear weapons plant (weapons components and research) in Jefferson County, Colorado has routinely released plutonium (Pu) and other actinides and radionuclides in the exhaust from plant smokestacks since 1953 (1). Plutonium is a very potent carcinogen and considered the most important risk to health, and so is monitored on a regular basis. Release of other actinides and radionuclides is checked less frequently (1).

While exhaust ducting filters—five high efficiency particulate air (HEPA) filters in series—effectively remove Pu particulates larger than 0.3 micrometers (μm) in diameter from the exhaust stream (13 000 000 m^3 daily from the main stack), leaks do occur (2) and one report (1972) estimates “the number of individual particles emitted from 776 Building to be on the order of millions per day” (3). About half the particles are below 0.1 μm in diameter and behave like gas molecules (3). In addition, small particles of Pu (Pu oxide) and other alpha radiation-emitting nuclides can diffuse through the filter arrangement due to the constant fragmentation and selfscattering effect of the alpha recoil phenomenon (Table 1) (4). There is a “dissemination of the finest radionuclide particles throughout the area over a radius of several miles from the plant site” and “these smallest particles are not noticeably reduced in number by gravitational settling to three miles from the apparent point of origin and presumably reached much further afield” (5, 6).

Sampling stations draw air from the filtered exhaust stream through a collecting filter. An evaluation of filter efficiency in which two millipore filters were arranged in tandem disclosed a “large and variable percent of the particles on the backup filter” (32–69 percent), indicating an underestimation of Pu releases (5, 6).

Routine releases of Pu in exhaust from the plant ranged from an annual average concentration of 0.03 picocuries of 0.06 disintegrations per minute per cubic meter (pCi/m^3 or dpm/m^3) in 1953 to 1.05 pCi or 2.33 dpm/m^3 in 1962 (Table 1) compared to a guideline limiting Pu in plant exhaust to less than 0.12 dpm/m^3 (7). Plutonium concentrations in the air at the Rocky Flats plant are consistently the highest (1970–1977) in the US Department of Energy (DOE) monitoring network, which has 51 stations positioned throughout the western hemisphere (8). The DOE station at the eastern (downwind) boundary of the

plant has recorded an average concentration of 2072 attocuries/m³ (aCi/m³) of plutonium over the eight year period, compared to 32 aCi/m³ for New York City and 5 aCi/m³ for the station with the lowest concentration (8).

The air concentrations of Pu obtained from ambient air monitors are of dubious validity, because, as Chapman states "Although we maintain air samplers in neighboring populated areas, these are not visited daily because of the cost involved and because we found them to give the same value as air samplers collected daily on site. The samplers are visited fortnightly principally to insure that they are operating and can be used as a defensive measure in case of an incident on the plant site. Consequently, dust loading restricts the air flow and gives an unrealistically low computed value for air activity. To transmit these values would raise questions of falsification of data in the minds of lay readers because they are about an order of magnitude lower than those reported from the air sampling stations of other observers" (9). In addition to problems with dust loading, incompatible wind speeds, and the diffusion through filters of alpha active aerosols, these filters are less efficient than the industrial HEPA filters through which the Pu particulates have already passed.

Unusual releases have occurred, especially in major fires in 1957 and 1969 (7, 8, 10, 11). Average measured concentrations of Pu in exhaust plumes from the main stack at the plant were as high as 948 pCi/m³ for the eighth day after a fire and explosion in 1957, which blew out the filter system (12-14). There are no records of emissions for the seven-day period during the fire and after, but those unmeasured releases may have been 4 to 5 orders of magnitude greater than the releases recorded on the eighth day (an estimated 12 millicuries, or about 200 mg of Pu) (12-14). The releases of Pu and other transuranics in the 1957 fire may represent the most important exposure to the population near the plant during the period 1953-1971. "The 620 HEPA filters in the main plenum had not been changed since they had been installed four years earlier and may have contained many kilograms of Pu (estimates range as high as 250 kg or about 15 000 curies). Large plumes of Pu-contaminated smoke from the 150 foot high stack continued throughout the night. Eyewitnesses reported it to be very dark in color, 80 to 100 feet high, blowing south, east and southeast" (12-14).

Estimates of the amount of Pu released are based on a study which found that an average of 13 grams of Pu were deposited

| Month | 1954(b) | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 |
|----------------|---------|------|------|-----------|------|------|------|------|------|
| Jan | 0.03 | 0.11 | 0.06 | 0.36 | 0.46 | 2.84 | 0.13 | 2.84 | 0.68 |
| Feb | 0.03 | 0.11 | 0.05 | 0.08 | 0.96 | (d) | 0.16 | 1.21 | 7.79 |
| Mar | 0.04 | 0.11 | 0.06 | 0.64 | 5.59 | 0.25 | 0.08 | 0.72 | 0.92 |
| Apr | 0.02 | 0.12 | 0.07 | 0.08 | 0.35 | 0.18 | 0.09 | 1.24 | 1.24 |
| May | 0.05 | 0.08 | 0.21 | 0.04 | 4.97 | 0.15 | 0.40 | 1.20 | 0.89 |
| Jun | 0.03 | 0.05 | 0.09 | 0.20 | 5.66 | 0.56 | 0.94 | 1.13 | 0.34 |
| Jul | 0.07 | 0.04 | 0.23 | 0.40 | 3.19 | 1.87 | 0.53 | 0.77 | 0.54 |
| Aug | 0.06 | 0.02 | 0.20 | 0.09 | 0.80 | 1.05 | 1.42 | 1.21 | 1.32 |
| Sep | 0.06 | 0.12 | 0.23 | (c) | 1.73 | 0.89 | 0.69 | 1.20 | 1.47 |
| Oct | 0.06 | 0.05 | 0.58 | 6.64 | 0.81 | 0.57 | 3.26 | 0.60 | 5.03 |
| Nov | 0.10 | 0.06 | 0.33 | 0.50 | 0.42 | 0.19 | 1.32 | 0.85 | 2.44 |
| Dec | 0.14 | 0.04 | 0.15 | 2.01 | 1.25 | 0.12 | 1.12 | 0.44 | 5.33 |
| Annual Average | 0.06 | 0.08 | 0.19 | 110 + (e) | 2.18 | 0.96 | 0.85 | 1.12 | 2.33 |

- (a) Federal guideline for maximum permissible air concentrations for such exhaust plumes is 0.12 dpm/m³. Daily exhaust volume from main stack exceeds 13 000 000 m³.
 (b) Data incomplete for 1953 (average 0.03 dpm/m³) and for 1963 (average 7.63 pCi/m³).
 (c) Fire on September 11, 1957. Sept. 1-10, 0.68 dpm/m³; Sept. 11-18, no sample (electrical power failure following a major fire). Sept. 19-30, 74.74 dpm/m³ and on Sept. 19, 2086.10 dpm/m³.
 (d) All filters changed in the main filter plenum. Feb. 1-13, 5.32 dpm/m³; Feb. 14-28, 0.21 dpm/m³.
 (e) Estimated, not including Pu released during the fire or for six days after.

Table 1. Monthly average plutonium 239 concentration, in disintegrations per minute per cubic meter (dpm/m³), in the air leaving the main exhaust duct of Building 771 (a) (from Reference 7).

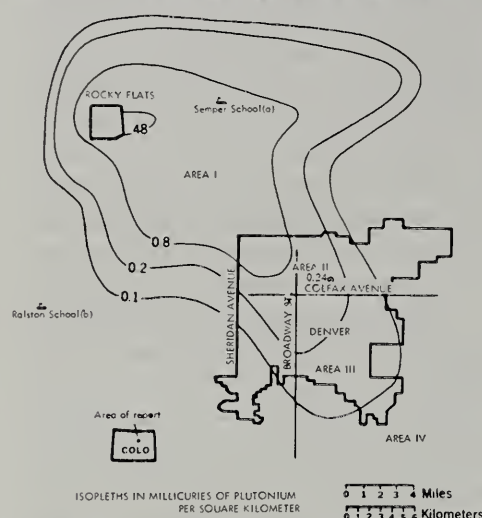


Figure 1. Denver area census tracts within isopleths for soil contamination with plutonium downwind from the Rocky Flats plant. The offsite soil contamination was reported on March 13, 1958 to be as follows (19):

- a) At the Semper Elementary School; 12 000 disintegrations per minute per kilogram (dpm/kg) of "possible enriched uranium".
 b) At the Ralston Elementary School; 16 000 dpm/kg of "possible enriched uranium".
 c) "Possible plutonium", 18 000 dpm/kg on private property east of the Rocky Flats plant.

daily on the first-stage filters (15,16). The filters in that system had been in operation no more than four months, and each filter contained as much as 68 grams of Pu. The average amount ranged from 16.6 grams (26 days) to 42 grams (4 months). In one month the filters could collect 0.5 kilograms or more of plutonium, of which 86 percent was water-soluble, (Pu nitrate) due to nitrates present in the exhaust (17). When the stack monitors were placed back in operation eight days after the fire, the guidelines for stack emissions were exceeded by 16 000 times for that day, greater than a permitted release over a 50-year period.

An unknown quantity (14-20 kg) of Pu metal burned up in the fire. Burning Pu forms submicron-sized particles of pluto-

onium oxide. According to a report made by the Atomic Energy Commission (AEC), these particles do not settle out from industrial exhaust plumes, and are so small as to move like metal fumes and do not account for the pattern of soil contamination around the plant (18).

There was concern about offsite contamination with plutonium by the fire. However, only three offsite soil samples were taken (19). All showed contamination by the plant. A soil sample taken at the Ralston Elementary School 12 miles south-southwest of the plant contained 12 000 dpm/kg of "possible enriched uranium" and a sample taken at the Semper Elementary School six miles east of the plant contained 16 000 dpm/kg of "possible enriched uranium" (Figure 1). A third sample from private property contained 18 000 dpm/kg of "possible plutonium". These concentrations are 150 to 225 times higher than Pu concentrations in soil from accumulated worldwide fallout from nuclear weapons' testing according to measurements of "background levels" in Colorado soil, or between 4200 and 6300 times higher than the "background level" (0.003 dpm/g) measured in South Carolina (20). These soil concentrations only indicate the passing of a very heavily contaminated smoke plume containing very large amounts of Pu and other actinides and radionuclides. An official at the plant afterward requested a "crash" survey as part of a nationwide AEC Project, repeating a request in earlier telegrams for reports "containing information relating to radioactivity in the atmosphere and the fallout therefrom, which is of direct interest to and must be known by the public in order to evaluate dangers to life" (21).

A large area downwind from the facility (Figure 1) has been contaminated with isotopes of Pu and other radionuclides (22-29). Uranium has been released by the open burning of over 1000 barrels of con-

| Country | Milli-curies per km ² | Micro-curies per m ² | Disintegrations per minute per g. dry soil or per cm ² | Purpose | Type |
|---------|----------------------------------|---------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| USSR | — | 0.002 | 0.44 | hands and work under-clothing before cleaning | Occupational |
| | — | 0.006 | 1.33 | work surfaces after cleaning | Occupational |
| | — | 0.015 | 3.33 | work clothing and surfaces before cleaning | Occupational |
| US | 10 | 0.01 | 2.20 | Colorado: Surface soil | Occupational |
| | — | 0.02 | 4.40 | Interstate Commerce Commission (Dept. of Transportation) pertains to interior of vehicles previously used for transportation of radionuclides | Occupational |
| | 40 | 0.04 | 8.80 | urban, suburban, recreation areas (a) | Public |
| | 200 | 0.2 | 44.00 | soil surface in residential areas (U.S.E.P. A. proposed) | Public |
| | — | 0.35 | 77.00 | establishes an "extraordinary nuclear occurrence" (6) | Public |
| | | | | | |

(a) Recommended by U.S. at an International Symposium on Radiological Protection of the Public in a Nuclear Mass Disaster (June, 1968) (Reference 22).
(b) U.S. Code of Federal Regulations, Chapter 10, Sections 140–84, 140–85. US Nuclear Regulatory Commission, Washington, DC (1968).

Table 2. Guidelines concerning contamination concentrations of alpha radiation (plutonium) for areas that provide risk to human exposure (from Reference 22).

taminated lathe oil (30). In addition, waste lathe oil from the milling of Pu metal stored in several thousand corroded barrels outdoors at the plant spilled out on the ground between 1958 and 1968, and contributed at least 5.8 curies to the offsite contamination (30).

Concentrations of Pu in soil may be compared to current and proposed guidelines for areas with risk of human exposure. Only a Soviet standard of 0.44 dpm/cm², or 0.44 dpm/g of soil (by convention) is in the same order as the surface soil concentrations of Pu in the major part of the area studied (Table 2) (22). An Interstate Commerce Commission guideline for trucks hauling radioactive materials permits a concentration 10 times greater (4.4 dpm/cm²), but is 10 times more protective than a proposed Environmental Protection Agency (EPA) guideline to protect the general public (44 dpm/cm²), a guideline that has been criticized.

Resuspension of Pu-contaminated soil increases with wind speed to the 2.1 power, and the ratio of Pu 238 to Pu 239 increases from about 2 percent (surface soil) to 20–40 percent in airborne soil (31). As much as 50 pCi/g of Pu in airborne soil has been reported in the area. A study of Pu particle size in the soil suggested that single Pu atoms and Pu particles with diameters less than the minimum detectable equivalent diameter (0.09 μ m) accounted for the majority of Pu 239 and Pu 240 activity in the soil (32).

Contamination of an aquifer under the facility to 2.5 picocuries of Pu per liter (pCi/l), a stream leaving the plant site to 209 pCi/l (1), and a nearby water district to

2.29 pCi/l has been reported (1, 33). Pu in chlorinated water is soluble to the extent that a recommendation has been made that the concentration limit be reduced from 1600 pCi/l to 0.16 pCi/l (26, 27), so these concentrations of Pu are of concern (34, 35).

Contaminated water is a significant source of exposure for only a small fraction of the Denver area population (1). The major route of exposure is the inhalation of airborne particles of Pu and other radionuclides by people living in the path of exhaust plumes from the plant, and (for those living near the plant), the inhalation of Pu in resuspended surface dust. No reports of measured population doses have been made, but work in progress confirms the presence of Pu from the facility (identified by isotope ratio) in autopsy specimens of persons in the area (36).

There has been no prior investigation of health effects for residents of areas contaminated by Pu. (Pu, an alpha radiation emitter, has a very slow rate of excretion and is thus retained in the body for many years.) Although Pu is present in exposed persons in higher concentration in bone (where the half-life is about 200 years) autopsy studies of nuclear plant workers have demonstrated Pu in all organs (37). Animal studies suggest that effects of Pu may include leukemia, neoplasms of bone, lung and liver, and genetic injury (38, 39). Conservative reports suggest that maximum permissible doses of Pu for workers should be reduced to about 67 pCi (trachibronchial lymph nodes), or about 170 pCi (bone) (40, 41). Inhalation and retention of a few particles of Pu of

respirable size (<5 μ m in diameter) could exceed this amount (42). Lymphocyte chromosome aberrations in Pu workers in the lowest exposure group (1–10 percent maximum permissible body burden of Pu, or 400 to 4000 pCi) exceeded by 33 percent those of workers with no measurable body burden (43), further supporting a more conservative estimate of the body burdens of Pu having potential health effects.

A preliminary study of leukemia and lung cancer deaths compared eight census tracts around the facility with 19 census tracts with a similar population in the relatively uncontaminated part of the county (a census tract is a small area designated for statistical purposes in certain cities and in standard metropolitan statistical areas—SMSA's—in the United States). A higher age-corrected leukemia death rate was noted in the contaminated area ($p = 0.01$) and the age-specific (45–64 years) death rate from lung cancer was more than twice as great as for the control area ($p < 0.05$) (44, 45). A preliminary study of congenital malformations coded at birth found a rate of 14.5 per 1000 births for a large suburban city near the plant compared with a rate of 10.4 for the remainder of the county, and 10.1 for the state of Colorado, a difference of interest (47).

In order to determine if exposure of a large population to a small concentration of Pu and other radionuclides had produced a measurable effect on cancer incidence, the following investigation was conducted.

METHOD

Cancer incidence data was acquired by census tract from the National Cancer Institute's (NCI) Third National Cancer Survey (1969–1971) with the assistance of the Colorado Regional Cancer Center (48–50). The incidence of cancer for each cancer class was determined for census tracts pre-selected within Pu isopleth areas (Figure 1) with decreasing concentration of Rocky Flats Pu (identified by isotope ratio) in soil, based on an area-wide survey (core samples to a depth of 10 cm) made by the AEC in the Denver area in 1970 (18, 24). Census tracts divided by an isopleth were included in the area containing the major part of the census tract.

The isopleths in Figure 1 are approximate but useable in comparing the incidence of health effects between areas with decreasing environmental contamination around a point source of emission and with populations that are similar in size. Area I, within the Pu concentration range 40–0.8 millicuries/km² (mCi/km²), lies between 3 and 21 km from the center of the Rocky Flats Plant along the principal wind

| | Distance from Rocky Flats on principal vector | Plutonium mCi km ² (soil < 2 mm) ^(b) | Anglo Population | | Population Characteristics | | | Incidence of cancer compared to unexposed population | | | | | |
|-------------|-----------------------------------------------|------------------------------------------------------------|------------------|---------|---------------------------------------|------------------------------|------------------|------------------------------------------------------|------------------------------|----------------------|---------------|-------|-------------------|
| | | | Male | Female | Median Education years ^(c) | Median Income ^(c) | Median Age Years | | Male | | Female | | Total |
| | | | | | | | Male | Female | Cases obs/exp ^(d) | o/e-1 ^(c) | Cases obs/exp | o/e-1 | |
| Area I | 3-21 km | 48.0-0.8 | 75 250 | 78 920 | 12.04 | \$ 8 891 | 25.8 | 29.8 | 644/519** | + 24% | 636/581* | + 10% | 1280/110** + 16% |
| Area II | 21-29 km | 0.8-0.2 | 90 300 | 103 900 | 11.85 | 6 367 | 34.6 | 36.8 | 1086/947** | + 15% | 1154/1100 | + 5% | 2240/2047** + 10% |
| Area III | 29-35 km | 0.2-0.1 | 117 370 | 129 530 | 12.69 | 12 094 | 30.6 | 33.5 | 1078/1000 | + 8% | 1149/1109 | + 4% | 2227/2109 + 6% |
| Areas I-III | 3-35 km | 48.0-0.1 | 282 920 | 312 350 | 12.22 | 8 668 | | | 2808/2466** | + 11% | 2939/2790** | + 5% | 5747/5256** + 9% |
| Area IV | >35 km | <0.1 | 210 670 | 213 190 | 12.97 | 8 055 | 24.2 | 25.9 | 1114 | 0 | 1260 | 0 | 2374 0 |

(a) Ref 48, the National Cancer Institute's Third National Cancer Survey: Incidence Data (expected case numbers calculated by applying the SMSA age-specific cancer incidence rates to the corresponding age groups in each area, and summing the products to obtain a standardized expected incidence (cases expected/area population) for each area. The study areas are then compared to the control area. "Anglo" includes all white except those with Spanish surname.

(b) Millicuries per square kilometer, calculated from Pu concentrations in soil to 10 cm in depth, including gravel < 2 mm in diameter

(c) This data is for total population (49)

(d) $X^2 = \frac{(obs - exp - 0.5)^2}{npq}$ where n = population size, p = incidence of cancer, and q = 1 - p. The X^2 used with the variance = npq is a more conservative test than the Mantel-Haenszel X^2 (58). Use of a somewhat more conservative test devised by Professor Lars Ehrenberg of the University of Stockholm, $Z = \frac{n_1 - n_2}{\sqrt{n_1 + \frac{(n_1)^2}{n_2}}}$ did not change the level of significance noted here and in Table 4

* Critical X^2 value at a 95% confidence level. ** Critical X^2 value at a 99% confidence level.

(e) (observed/expected - 1) X 100, compared to Area IV, the unexposed population.

Table 3. Census tract areas selected by decreasing soil concentrations of Rocky Flats plutonium, Anglo population size, median income and education, and total incidence of cancer for 46 cancer sites, by sex, for the period 1969-1971 (a)

| | Area I 48-0.8 millicuries/kilometer ² | | | | | Area II 0.8-0.2 millicuries/kilometer ² | | | | | Area III 0.2-0.1 millicuries/kilometer ² | | | | | Area IV (unexposed) | |
|--------------------------------------|-----------------------------------------------------|----------|------------------------|-------|-------|-------------------------------------------------------|-------|-------------------------|-------|-------|--------------------------------------------------------|-------|-------------------------|-------|-------|------------------------|-------------------|
| Population (1970) | 75,250 Male Cases | | 78,920 Female Cases | | Total | 90,300 Male Cases | | 103,900 Female Cases | | Total | 117,370 Male Cases | | 129,530 Female Cases | | Total | 210,670 Male | 213,190 Female |
| Site | obs/exp(b) | o/e-1(c) | obs/exp | o/e-1 | o/e-1 | obs/exp | o/e-1 | obs/exp | o/e-1 | o/e-1 | obs/exp | o/e-1 | obs/exp | o/e-1 | o/e-1 | obs | obs |
| Lung and Bronchus | 109/82* | 33% | 21/24 | (12%) | 23% | 209/143** | 46% | 53/48 | 10% | 37% | 179/158 | 13% | 54/48 | 12% | 13% | 174 | 51 |
| Other Respir- atory | 20/13 | 54% | 3/2 | 50% | 53% | 21/23 | (9%) | 7/5 | 40% | 0 | 26/26 | 0 | 2/5 | (60%) | (10%) | 32 | 5 |
| Leukemia | 27/19 | 42% | 14/17 | (18%) | 14% | 28/31 | (10%) | 34/33 | 3% | (3%) | 37/34 | 9% | 52/33** | 58% | 33% | 45 | 38 |
| Lymphoma, Myeloma | 35/25 | 40% | 28/25 | 12% | 26% | 48/40 | 20% | 38/49 | (22%) | (3%) | 51/45 | 13% | 43/49 | (12%) | 0 | 59 | 56 |
| Tongue, Pha- rynx, Esopha- gus | 17/12 | 42% | 6/3 | 100% | 53% | 43/18** | 139% | 25/7** | 257% | 172% | 29/20 | 45% | 10/7 | 43% | 44% | 24 | 7 |
| Stomach | 22/16 | 38% | 11/14 | (21%) | 10% | 27/30 | (10%) | 27/32 | (16%) | (13%) | 30/32 | (6%) | 21/23 | (9%) | (7%) | 34 | 27 |
| Colon, Rectum | 100/68* | 47% | 103/75** | 37% | 42% | 144/130 | 11% | 178/160 | 11% | 11% | 135/135 | 0 | 152/143 | 6% | 3% | 144 | 146 |
| Liver and Biliary | 10/5 | 100% | 7/10 | (30%) | 13% | 23/13* | 77% | 23/22 | 5% | 31% | 19/13 | 46% | 19/21 | (10%) | 12% | 5 | 3 |
| Pancreas | 20/22 | (9%) | 21/15 | 40% | 11% | 37/41 | (10%) | 35/32 | 9% | (3%) | 39/43 | (9%) | 32/30 | 7% | (3%) | 46 | 30 |
| Testis | 11/5 | 120% | — | — | — | 14/6* | 133% | — | — | — | 15/7 | 114% | — | — | — | 13 | — |
| Ovary | — | — | 34/27 | 26% | — | — | — | 59/48 | 23% | — | — | — | 66/52 | 27% | — | — | 63 |
| Thyroid | 3/6 | (50%) | 24/16 | 50% | 23% | 8/10 | (20%) | 33/26 | 27% | 14% | 11/12 | (8%) | 23/29 | (21%) | (17%) | 18 | 42 |
| Brain | 13/11 | 18% | 10/8 | 25% | 21% | 10/17 | (41%) | 10/12 | (17%) | (31%) | 17/20 | (15%) | 19/14 | 36% | 6% | 27 | 20 |
| Other Sites | 257/235 | 9% | 354/345 | 3% | 6% | 474/445 | 8% | 632/625 | 3% | 5% | 490/455 | 8% | 656/655 | 0% | 3% | 493 | 772 |
| All Cancer | 644/519** | 24% | 636/581* | 10% | 16% | 1086/947** | 15% | 1154/1100 | 6% | 10% | 1078/1000* | 8% | 1149/1109 | 4% | 6% | 1114 | 1260 |

(a) From the National Cancer Institute's Third National Cancer Survey: Incidence Data. Expected case numbers calculated by applying the SMSA age-specific cancer incidence rates to the corresponding age groups in each area, and summing the products to obtain a standardized expected incidence (cases expected/area population) for each area. The study areas are then compared to the control area. "Anglo" includes all white except those with Spanish surname. (48)

(b) $X^2 = \frac{(obs - exp - 0.5)^2}{npq}$ when n = population size, p = incidence of cancer, and q = 1 - p. The X^2 used with the variance = npq is a more conservative test than the Mantel-Haenszel X^2 (58).

* Critical X^2 value at a 95% confidence level ** Critical X^2 value at a 99% confidence level

(c) (observed/expected - 1) X 100 compared to Area IV, the unexposed population. Percentages in parentheses are negative (less than expected).

Table 4. Anglo cancer incidence by sex, and by cancer site, in the Denver metropolitan area over a period of three years (1969-1971) by areas of census tracts with and without plutonium soil contamination by the Rocky Flats plant (a)

vector. Area II (0.8 to 0.2 mCi/km²) extends from 21 to 29 km and Area III (0.2 to 0.1 mCi/km²) from 29 to 35 km.

The Pu content of soil reported in the AEC survey was used as a surrogate measure of exposure through pathways other than those that originate from the soil (ie an indication of the direction of exhaust plumes from the Rocky Flats Plant since 1953). That actual exposures to radionuclides have been much larger is suggested by a survey of Pu in surface respirable dust to a distance of 32 km around the plant. Concentrations of Pu as much as 3390 times greater than that in Colorado "background" concentrations were ob-

served (169.5 dpm/g and 0.05 dpm/g respectively) compared to a maximum concentration of 26 times background for the AEC survey, which sampled subsurface soil and coarse particles 2 mm in diameter and smaller with the windblown material (18).

Data were retrieved from NCI automated data processing tapes using a program developed by Berg and Finch (50), with an approach similar to that reported by Monson (51), and most recently utilized by Blair, *et al* (52, 51). Age-specific cancer rates for whites (excluding persons with Spanish surname, because the population of the area near the plant is virtually all

white, with few persons of Spanish surname) were calculated for the Denver Standard Metropolitan Statistical Area (SMSA), and expected case numbers calculated by applying the SMSA age-specific cancer incidence rates to the 11 corresponding age groups in each sub-area, and summing the products to obtain a standardized expected incidence (cases expected/area population) for each area. The number of cases of all cancer or the classes of cancer in each area divided by the standardized expected incidence provided a risk ratio (observed/expected).

Area IV, the unexposed population (comprising the remainder of the Denver

SMSA) had an age-adjusted cancer incidence (males, 269 and females, 226 per 100 000) virtually identical to that for the state (males, 268 and females, 227 per 100 000) (48). The risk ratio for Area IV was assumed to be 1.0 and the exposed populations (Areas I-III) were compared to Area IV. The population in Area IV is predominantly suburban, as is the population for Area I nearest the plant, and these two areas have a mean age more similar (Table 3) than those of Areas II and III, and so those two areas provide the most important comparisons. Median income and education levels of the study and control populations were considered with the aid of 1970 census data (Table 3), in order to weigh the possible importance of such associated factors as smoking, diet and alcohol.

The population in the eight census tracts in Area I nearest the plant was small and had had rapid development and recent in-migration (an estimated population of 16 000 in 1960, and 44 000 in 1970, during which time the population of Denver did not appreciably change) (49). Area IV, like Area I, is mostly suburban, and part of this area also had a rapid growth in population between 1960 and 1970. The evidence indicates heaviest exposures in 1957. Since there is a latent period for neoplasms, many persons in the eight census tracts nearest the plant would not have had sufficient time in residence to exhibit an effect from exposure to Pu. An influence on cancer incidence would be first apparent in the large population areas with lower rates of in-migration. The effect of the inclusion of the eight census tracts nearest the plant with the remainder of Area I is to understate any environmentally-related difference in cancer incidence.

RESULTS

The total incidence of cancer for the period 1969-1971 is summarized in Table 3 for 46 cancer classes by isopleth area of Pu concentration. Compared to males in the unexposed area (Area IV), there was an incidence of cancer 24% higher in males in Area I, nearest the plant and 15% higher in Area II, further from the plant. (For confidence levels, see Table 3, column 10.) The corresponding values for females were 10% in Area I and 5% in Area II, and for both sexes 16% and 10%. The higher incidence of all cancer in the exposed areas represents more cases than expected (both sexes) of cancer of the lung, leukemia, lymphoma and myeloma (only males), and cancer of the tongue, pharynx and esophagus, colon and rectum, liver, (only males) pancreas, only females) gonads, thyroid (only females) and

brain (only females).

The incidence of lung and bronchial cancer for males in Area I was about 33 percent higher than for males in the uncontaminated area (Table 4). This higher incidence persisted in Area II (46% higher). In all exposed areas, 497 cases were observed where 383 were expected, for males. For both sexes in all exposed areas, 625 cases were observed where 503 were expected.

There was a significant excess (58%) of cases of leukemia in females in Area III, with the largest study population. For both sexes in all exposed areas, 192 cases of leukemia were observed where 167 were expected. There was a higher incidence of lymphoma and myeloma in males in all exposed areas (134 cases observed/110 expected).

A most unexpected discovery was the unusually high incidence of cancer of the testis (40 cases observed/18 expected) throughout the exposed area (Areas I-III) (53-55). The incidence of cancer of the ovary was also higher (24%) throughout the exposed areas.

The incidence of cancer of the colon and rectum was much higher for both males and females in Area I (42% higher for both sexes) and for all exposed areas (812 cases observed/711 expected). The incidence of cancer of the liver, gall bladder and "other biliary" was higher in males throughout the three exposed areas (77% higher in Area II; for all exposed areas, 52 cases observed/31 expected). Cancer of the tongue, pharynx, and esophagus was high for both sexes in all three study areas (89 cases observed/50 expected for males, and 41 cases observed/17 expected for females). According to the statistical test used, the remaining variances may be random.

The strongest comparisons can be made between Area I, a predominantly suburban area near the plant with heaviest exposure, and Area IV, also predominantly suburban with little or no exposure and having virtually the same age-adjusted incidence rate for all cancer as that for the state of Colorado. The number of cancer cases observed for these two areas in the three-year study period are compared by age and sex in Table 5.

For both sexes, the general pattern is that of excess incidence of all cancer in all age categories in Area I, with no significant exception. There was an excess of all cancer in the age group 0-14 years (25 observed/16 expected), 15-44 years (155/123), 55-64 years (277/247), 65-74 years (338/251) and over 75 years (312/277). This difference was due principally to an excess of cancer in males in the age groups 0-14 years, 15-44 years, 65-74 years, and

over 75 years. An excess incidence of all cancer was also noted in females with no significant exception, especially in the age group of 15-44 years and 65-74 years.

The higher incidence of all cancer was chiefly due to cancer of lung and bronchus, especially in the males, and to cancer of the colon in both sexes. The incidence was higher above the age of 55. Exceptions were an excess of cancer of the lung and bronchus in males in the age range 15-44 years and cancer of the colon in females in the age group 45-64 years.

There was a higher incidence of leukemias, lymphomas and myelomas in both sexes in Area I. In males there was a higher incidence of leukemia in the age group 15-44 years of age (13/2.9) and of lymphomas and myelomas in the age group 15-44 years (19/7.3). In females, there was a higher incidence of leukemia in the age group 55-64 (7/0.9) and of lymphomas and myelomas in the age groups 15-44 years (19/7.0), 55-64 years (9/2.4), and 75+ years (11/3.1).

A higher incidence of breast cancer was found for females in the age group 65-74 years (46/27). This age-specific excess incidence was obscured when the data was age-adjusted.

The incidence of cancer of the testis is again noted, with one case occurring in the small population (24 825) in the age category 0-14 near the plant and none occurring in the larger control population (66 530). In the next older age category, 15-44, eight cases were observed where 3.2 were expected.

With one exception (ages 65-74), there were more cases of cancer of the thyroid in females than expected, and an excess of cancers of unknown origin, especially in the age range 65-74 years.

Investigation of the ratios of cancers of radiosensitive organs to other cancers (Table 6) found higher ratios in the population near the plant, compared to the unexposed population in Area IV (+12.2%, +9.7% and +3.4%, respectively, for both sexes in Areas I, II and III). Males had a higher ratio near the plant, 17.6% higher, than did the females (11.9% higher). Deleting lung cancer changed only slightly the ratio of cancers of radiosensitive organs to other cancers (11.7% higher for both sexes; 17.9% for males and 13.6% for females).

DISCUSSION

The incidence of all cancer in the suburban area near the plant (Area I) was significantly higher than that in the unexposed population (Area IV) which had virtually the same age-adjusted cancer incidence as the state. Exposed Area II, more distant from the plant, had a correspon-

| Male | | | | | | | | | | | | |
|--------------------------|---------|---------|----------|---------|---------|--------|----------|--------|-----------|--------|-----------|-------|
| Age Category | 0-14 | | 15-44 | | 45-54 | | 55-64 | | 65-74 | | 75 + | |
| (Population: Area I, IV) | 24,825 | 66,530 | 31,395 | 98,521 | 8,351 | 24,092 | 5,750 | 12,652 | 3,148 | 5,683 | 1,785 | 3,175 |
| Cancer Classes | o/e (b) | E (c) | o/e | E | o/e | E | o/e | E | o/e | E | o/e | E |
| All classes | 20/9 1* | 25 | 52/40 | 126 | 71/64 | 185 | 147/127 | 278 | 194/149** | 270 | 169/130** | 230 |
| Lung and bronchus | 0/0 | 0 | 8/3.5 | 11 | 14/13 | 37 | 37/25 | 54 | 34/31 | 55 | 16/9 6 | 17 |
| Leukemia | 6/4 2 | 11 | 13/2.9** | 9 | 1/1.0 | 3 | 6/1.8 | 4 | 2/1.7 | 3 | 2/1.1 | 2 |
| Lymphoma, myeloma | 1/1.9 | 5 | 19/7.3** | 23 | 3/1.4 | 4 | 8/2.7 | 6 | 5/1.7 | 3 | 3/1.1 | 2 |
| Stomach | 0/0 | 0 | 1/0.3 | 1 | 6/2.1 | 6 | 3/3.2 | 7 | 8/6.1 | 11 | 4/5.1 | 9 |
| Colon | 0/0 | 0 | 3/2.5 | 8 | 6/5.2 | 15 | 15/12 | 26 | 15/9.4 | 17 | 29/13** | 23 |
| Liver | 0/0 | 0 | 0/0.3 | 1 | 0/0.3 | 1 | 3/0 | 0 | 1/0.6 | 1 | 2/1.1 | 2 |
| Pancreas | 0/0 | 0 | 1/0.6 | 2 | 3/3.5 | 10 | 6/4.1 | 9 | 7/6.6 | 12 | 3/7.3 | 13 |
| Testis | 1/0 | 0 | 8/3.2 | 10 | 1/0.7 | 2 | 0/0.5 | 1 | 1/0 | 0 | 0/0 | 0 |
| Breast | 0/0 | 0 | 1/0.3 | 1 | 0/0 | 0 | 0/0 | 0 | 1/0 | 0 | 0/0.6 | 1 |
| Thyroid | 0/0 | 0 | 1/3.2 | 10 | 1/1.4 | 4 | 0/1.4 | 3 | 1/0.6 | 1 | 0/0 | 0 |
| Brain | 1/0.4 | 1 | 2/2.2 | 7 | 3/1.7 | 5 | 4/2.3 | 5 | 2/3.3 | 6 | 1/1.7 | 3 |
| Unknown | 0/0 | 0 | 0/0.6 | 2 | 3/1.4 | 4 | 4/5.5 | 12 | 11/3.9* | 7 | 5/2.8 | 5 |
| Female | | | | | | | | | | | | |
| (Population: Area I, IV) | 23,648 | 64,433 | 33,113 | 99,552 | 8,727 | 23,379 | 6,140 | 12,963 | 4,031 | 7,593 | 3,257 | 5,273 |
| All classes | 5/7.0 | 19 | 103/84 | 253 | 106/116 | 310 | 130/118 | 249 | 144/104** | 195 | 148/144 | 234 |
| Lung and bronchus | 0/0 | 0 | 2/1.3 | 4 | 2/5.6 | 15 | 5/5.2 | 11 | 9/7.5 | 14 | 3/4.3 | 7 |
| Leukemia | 0/1.8 | 5 | 5/1.3 | 4 | 0/1.1 | 3 | 7/0.9* | 2 | 2/1.1 | 2 | 1/2.5 | 4 |
| Lymphoma, myeloma | 1/0.7 | 2 | 19/7.3** | 21 | 1/0.7 | 2 | 9/2.4* | 5 | 5/2.1 | 4 | 11/3.1* | 5 |
| Stomach | 0/0 | 0 | 1/0.3 | 1 | 0/1.1 | 3 | 2/3.3 | 7 | 2/1.6 | 3 | 6/8.0 | 13 |
| Colon | 0/0 | 0 | 3/4.0 | 12 | 8/0.9 | 23 | 14/8.5 | 18 | 16/8.5 | 16 | 39/25* | 40 |
| Liver | 0/0 | 0 | 0/0.7 | 2 | 0/0.4 | 1 | 0/0 | 0 | 1/0 | 0 | 2/0 | 0 |
| Pancreas | 0/0 | 0 | 2/0.3 | 1 | 2/2.2 | 6 | 9/4.3 | 9 | 5/3.2 | 6 | 3/4.9 | 8 |
| Ovary | 0/0 | 0 | 8/5.3 | 16 | 7/7.5 | 20 | 9/6.2 | 13 | 7/4.2 | 8 | 3/3.7 | 6 |
| Breast | 0/0 | 0 | 34/34 | 101 | 40/44 | 119 | 37/30 | 64 | 46/27* | 51 | 33/30 | 49 |
| Thyroid | 1/0 | 0 | 12/8.3 | 25 | 3/2.6 | 7 | 4/0.9 | 2 | 0/2.7 | 5 | 4/1.8 | 3 |
| Brain | 2/1.8 | 5 | 3/2.0 | 6 | 1/0.7 | 2 | 2/1.9 | 4 | 2/1.1 | 2 | 0/0.6 | 1 |
| Unknown | 0/0 | 0 | 1/0.7 | 2 | 2/2.6 | 7 | 3/0.9 | 2 | 7/5.9 | 11 | 8/6.2 | 10 |
| Total | | | | | | | | | | | | |
| (Population: Area I, IV) | 48,473 | 130,963 | 64,508 | 198,073 | 17,078 | 47,471 | 11,890 | 25,615 | 7,179 | 13,276 | 5,042 | 8,448 |
| All classes | 25/16 | 44 | 155/123* | 379 | 177/178 | 495 | 277/247* | 527 | 338/251** | 465 | 312/277 | 464 |
| Lung and bronchus | 0/0 | 0 | 10/4.9 | 15 | 16/19 | 52 | 42/30 | 65 | 43/37 | 69 | 19/14 | 24 |
| Leukemia | 6/5.9 | 16 | 18/4.2** | 13 | 1/2.2 | 6 | 13/2.8** | 6 | 4/2.7 | 5 | 3/3.6 | 6 |
| Lymphoma, myeloma | 2/2.6 | 7 | 38/14** | 44 | 4/2.2 | 6 | 17/5.1** | 11 | 10/3.8* | 7 | 14/4.2** | 7 |
| Stomach | 0/0 | 0 | 2/0.6 | 2 | 6/3.2 | 9 | 5/6.5 | 14 | 10/7.8 | 14 | 10/12 | 20 |
| Colon | 0/0 | 0 | 6/6.5 | 20 | 14/17 | 48 | 29/20 | 44 | 31/18* | 33 | 68/38** | 63 |
| Liver | 0/0 | 0 | 0/1.0 | 3 | 0/0.7 | 2 | 3/0 | 0 | 2/0.5 | 1 | 4/1.2 | 2 |
| Pancreas | 0/0 | 0 | 3/1.0 | 3 | 5/5.8 | 16 | 15/8.4 | 18 | 12/9.7 | 18 | 6/13 | 21 |
| Gonads | 1/0 | 0 | 16/8.5* | 26 | 8/7.9 | 22 | 9/6.5 | 14 | 8/4.3 | 8 | 3/3.6 | 6 |
| Breast | 1/0 | 0 | 35/33 | 102 | 40/42.8 | 119 | 37/30 | 64 | 47/28** | 51 | 33/30 | 50 |
| Thyroid | 1/0 | 0 | 13/11 | 35 | 4/4.7 | 13 | 4/2.3 | 5 | 1/3.2 | 6 | 4/3.6 | 3 |
| Brain | 3/2.2 | 6 | 5/3.6 | 13 | 4/2.5 | 7 | 6/4.2 | 9 | 4/4.3 | 8 | 1/2.4 | 4 |
| Unknown | 0/0 | 0 | 1/1.3 | 4 | 5/4.0 | 11 | 7/6.5 | 14 | 18/9.7* | 18 | 13/9.0 | 15 |

(a) Ref. 48 The National Cancer Institute's Third National Cancer Survey: Incidence Data

(b) o = observed cases in Area I, e = expected number of cases (actual number of cases in Area IV × population in Area I/population in Area IV)

(c) E is the number of cases in Area IV

* p < 0.05

** p < 0.01 (standardized Z test for normal approximation to the binomial proportion, ref. 58)

Table 5. Anglo cancer incidence by sex, age and by cancer class, in the Denver metropolitan area over a period of three years (1969-1971) by areas of census tracts with and without plutonium soil contamination by the Rocky Flats Plant: Area I compared to Area IV (Control) (a).

| | Area | Population | Total cancer cases | (c) cancers of radiosensitive organs | (d) Other cancer cases | (e) ratio c/d | relative risk (e/e' - 1) × 100 |
|--------|------|------------|--------------------|--------------------------------------|------------------------|---------------|--------------------------------|
| Total | IV | 423 866 | 2374 | 1251 | 1123 | 1.114 | 0(e') |
| | I | 154 170 | 1280 | 711 | 569 | 1.250 | + 12.2% |
| | II | 194 190 | 2240 | 1232 | 1008 | 1.222 | + 9.7% |
| | III | 246 905 | 2227 | 1192 | 1035 | 1.152 | + 3.4% |
| Male | IV | 210 670 | 1114 | 500 | 614 | 0.814 | 0(e') |
| | I | 75 250 | 644 | 315 | 329 | 0.957 | + 17.6% |
| | II | 90 300 | 1086 | 507 | 579 | 0.876 | + 7.6% |
| | III | 117 370 | 1078 | 474 | 604 | 0.784 | - 3.7% |
| Female | IV | 213 670 | 1260 | 751 | 509 | 1.475 | 0(e') |
| | I | 78 920 | 636 | 396 | 240 | 1.650 | + 11.9% |
| | II | 103 900 | 1154 | 725 | 429 | 1.690 | + 14.6% |
| | III | 129 530 | 1149 | 718 | 431 | 1.666 | + 12.9% |

(a) "Cancers of radiosensitive organs" defined as those found in excess in survivors of Hiroshima and Nagasaki; leukemia, lymphoma and myeloma, and cancer of the lung, thyroid, breast, esophagus, stomach, and colon (from Reference 59).

(b) Cancer incidence data from the National Cancer Institute's Third National Cancer Survey: Incidence Data. The population in Area IV is considered a control population with no exposure to plutonium and other actinides and radionuclides from the Rocky Flats plant. The population in Area I has the greatest exposure to these radionuclides, those in Area II have less exposure, and those in Area III have the least exposure (from Reference 48).

Table 6. Anglo cancer incidence in the Denver metropolitan area over a period of three years (1969-1971), by areas of census tracts with and without plutonium soil contamination by the Rocky Flats Plant: A comparison of the ratios of cancers of radiosensitive organs (a) to other cancers by sex and by exposure to plutonium from the plant (b).

dingly smaller excess incidence of all cancer compared to Area IV. Area III, most distant from the plant, had an incidence of all cancer slightly greater than expected.

The data were corrected for age, sex, race and ethnicity. Other possible confounding factors include urban-suburban differences, income, education, air pollution, occupation, smoking habits, and diet. Data were not available by census tract for smoking, drinking and dietary habits, but these were assumed to be associated with income and education. Area II includes the Denver urban core (Figure 1), much of the low-income housing, and a lower educational and income level (usually associated with a higher incidence of cancer) but has a lower incidence of cancer than Area I, a suburban population near the Rocky Flats plant demographically similar to Area IV (Table 3). Area III has an educational level slightly higher than Areas I and II, and slightly lower than Area IV. This area has the highest income level, and has a higher

cancer incidence than Area IV. Differing levels of income and education do not appear to be important as a cause for the higher incidence of cancer in areas near the plant.

Area II has more air pollution than Area I, but has lower cancer incidence than Area I, which is nearer to the Rocky Flats plant. In considering occupation, the distribution of Rocky Flats Pu workers approximates the distribution of population between exposed and unexposed populations (1). Old radium mill tailing sites are located in Area II, under streets and parking lots and in commercial and industrial areas, and may cause an accumulation of radon in rooms in a small number of non-residential buildings. This would appear to have no noticeable effect on the results of this investigation (56).

The higher incidence of cancer in males accentuates a sex difference noted for the unexposed population and for the state. This is partly due to the smoking habits of men. Pulmonary irritants (*ie* cigarette smoke) can result in a greater respiratory deposition rate of small inhaled particles, such as Pu particles (57). Smoking habits alone can not account for the profile of classes of cancer found in excess, except for respiratory cancer.

Area I had a population with a younger mean age than Areas II and III (though not quite as young as Area IV), but had a higher cancer incidence than those two older urban areas. The method of age adjustment (see footnote for Tables 3 and 4) across the 11 age groups (NCI) should correct for these age differences, which are minor between the principal comparison populations in Area I and Area IV. The higher age-adjusted cancer incidence found in Area I was confirmed by age-specific comparison with Area IV.

The age-adjusted incidence of all cancer was significantly higher near the plant, due to more cases than expected of a number of individual classes of cancer, including those noted to be in excess in the survivors of Hiroshima and Nagasaki: leukemia, lymphomas and myelomas and cancer of the lung, thyroid, breast, esophagus, stomach and colon. Cancer of gonads (especially the testis) liver, pancreas and brain also contributed to the higher incidence of all cancer in the areas near the plant. The classes of cancer found to be in excess are for the most part those developing in the more radiosensitive tissues of the body. There was not an excessive incidence of bone cancer, perhaps because of its longer latent period.

The remarkably higher incidence of cancer of the testis in the three exposed areas merits special attention. One possi-

ble explanation is the demonstrated propensity of plutonium to concentrate in gonads (53-55). The higher incidence of cancer of the ovary is also consistent with this hypothesis.

That the age-adjusted rates of all cancer near the plant are higher is confirmed by an inspection of age-specific cancer incidence for Areas I and IV (Table 5). This was due in part to higher age-specific incidence of leukemia, lymphoma and myeloma, and cancer of breast, colon, and cancer, site unknown for certain age-specific groups. Cancer of the lung, stomach, liver, gonads, thyroid and brain also contributed to the higher incidence of all cancer near the plant. The general trend of all cancer of radiosensitive organs was clearly upward near the plant, but in some classes of cancer the numbers of cancer cases in each age category were too small in the three-year period of the investigation to be statistically significant.

Further indication that the populations in the path of exhaust plumes of the Rocky Flats plant have been affected is provided by an examination of the ratios of cancers of radiosensitive organs to other cancers, compared to that ratio for the unexposed population in Area IV (Table 6). These are the cancers found in excess in the survivors of Hiroshima and Nagasaki: leukemia, lymphomas and myelomas, and cancer of the lung, thyroid, breast, esophagus, stomach and colon. These cancers occurred in greater proportion than expected in the exposed population (12.2% higher in Area I for both sexes; 17.6% higher for males, and 11.9% higher for females). This ratio decreased in Areas II and III for males, but persisted for females. The exclusion of lung cancer (because smoking habits are an important factor in lung cancer) makes little change (11.7% higher for both sexes in Area I; 17.9% higher for males, and 13.6% higher for females).

CONCLUSION

A conservative analysis of cancer incidence in the Denver SMSA over a three-year period (1969-1971) found a higher incidence of all cancer in areas contaminated with Pu, compared to the unexposed area. The consistency of the increase in incidence of all cancer and for certain categories of cancer with increasing concentration of Pu in soil supports the hypothesis that exposure of the general public to low concentrations of Pu in the environment may have an effect on cancer incidence. The higher incidence of cancer in the areas near the plant were due to more cases than expected of leukemia, lymphoma and myeloma and cancer

of the lung, thyroid, breast, esophagus, stomach and colon, a pattern similar to that observed in the survivors of Hiroshima and Nagasaki. Cancer of gonads (especially the testis) liver, pancreas and brain contributed to the higher incidence of all cancer near the plant. Further study is warranted to pursue the investigation of poorly-understood, complex dose-effect relationships between the concentrations of many radionuclides in cells and organs and the incidence of cancer and other somatic and genetic effects in general populations residing near nuclear installations.

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November

1-4 **Evaluation of Medical Disabilities in the 1980's, with particular emphasis on those disability programs administered by the Social Security Administration.** Sponsor: National Association of Disability Examiners (N.A.D.E.); Host Chapter: Colorado Association of Disability Examiners; Site: Plaza Cosmopolitan Hotel, Denver, Colorado. Contact: Jean Rueschoff, President, Colorado Association of Disability Examiners, P.O. Box 24281 or 2121 S. Oneida, Suite 200, Denver, Colorado 80224. Tele: (303) 758-5539

1-5 **88th Annual Convention of the Association of Military Surgeons of the United States.** To be held at the Convention Center, San Antonio, Texas. The program will include continuing education offerings for physicians, dentists, nurses and many other disciplines. Contact: Mr. T. A. Glasglow, Chief, Corporate Planning, HQ, Aerospace Medical Division, Brooks Air Force Base, Texas 78235. Tele: (512) 536-3656 or CDR T.G. McMahon, Asst. Exec. Dir., AMSUS, P.O. Box 104, Kensington, Maryland 20795. Tele: (301) 933-2801.

2 **"Management Skills for Health Care Supervisors"**-Denver, Colorado. Contact: Beth Israel Education Center, 1601 Lowell Blvd., Denver, Colorado. Tele: (303)825-2190, ext. 266.

3-4 **Symposium on Diet and Exercise—Synergism in Health Maintenance:** Lake Buena Vista, Florida (Walt Disney World Complex). AMA Category 1 Credit on an hour-for-hour basis towards the physicians' Recognition Award of the AMA. 13 prescribed hours by the American Academy of Family Physicians. Fee: \$60. Contact: Department of Foods & Nutrition, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610. Therese Mondeika, R.D., Dept. of Foods & Nutrition (312) 751-6524.

5 **Neuropsychiatric Grand Rounds, 1-3 pm.** APA approved course for Category I credit. Developed by Colorado State Hospital to examine the relationship of neurological and psychiatric disorders. Colorado State Hospital, Pueblo, Colorado. Conference Room A. Contact: James H. Scully, M.D., 1600 W. 24th St., Pueblo, Colorado. Tele: (303) 534-1170.

8-15 **Update in Clinical Endocrinology & Infertility:** Hilton Head Inn, Hilton Head Island, South Carolina. Registration: Sunday, Nov. 8th. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, Colorado 80211. Tele: (303) 629-5333. Toll-free outside Colorado (800) 525-5810.

10-14 **"Cancer 1981/2001—An International Colloquium"**—Shamrock Hilton Hotel, Houston, Texas. Contact: Lisa Long or Joan Chin at (713) 792-3030. The University of Texas System Cancer Center, M. D. Anderson Hospital & Tumor Institute, Texas Medical Center, 6723 Bertner Avenue, Houston, Texas 77030.

11 **Regional Computerized Tomography/Neuroradiology/Ultrasound Conference,** Dept. of Radiology, Saint Luke's Hospital, Denver, Colorado, 5:30 pm to 9pm, Aspen Room, RSVP one week in advance. Contact: Suzanne Warner (303) 394-7774 (3 hours AMA Category 1 credit).

14 **Modern Drug Therapy of Common Pulmonary Diseases** at Medical Education Wing of the V.A. Medical Center, Fresno, California. 6 hours of AMA Category 1 credit; AAFP credit pending. Contact: Kathleen Wolff, Program Representative, c/o Area Health Education Center, 5110 East Clinton Way, Suite 210, Fresno, California 93727. (209) 252-1948.

14 **Ambulatory Medicine Symposium—Current Treatment of Common Office Care Problems.** Marriott Hotel, I-25 & Hampden Avenue, Denver. Sponsored by the Colorado Permanente Medical Group, P. C. Contact: Joyce Nordstrom (303) 961-3263. Write: 2005 Franklin Street, Denver, Colorado 80205. Credit: 7 hours of AMA Category 1 or AAFP prescribed credit.

15 **"Dilemmas With Drugs in Clinical Practice"**—Sheraton Universal Hotel, North Hollywood, California. Credit: 6 hours of Category 1 of the Physicians Recognition Award of AMA & the Calif. Medical Assoc. Certificate, and 6 Continuing Education hours. Contact: (213) 825-7257— UCLA Extension, P.O. Box 24901, Los Angeles, CA 90024.

17-20 **Region VIII Family Planning Conference - Management and Medical Update.** Location: Stouffer's Inn at the Airport, Denver, Colorado. Professional credit available for Physicians (CME - Category I), Nurses (CEUs), and Social Workers. Registration deadline October 25, 1981. Contact: M. Deborah Casselman, Region VIII Training Center, Rocky Mountain Planned Parenthood, 1525 Josephine, Denver, Colorado 80206. Telephone: (303) 321-2471.

20 **"Death & Dying"**—Beth Israel Hospital & Geriatric Center, Denver, Colorado. Contact: Beth Israel Education Center, 1601 Lowell

Blvd., Denver, Colorado 80204. (303) 825-2190.

20 **Paul R. Hackett Memorial Pediatric Anesthesia & Merry Simmons Critical Case Symposium**, sponsored by the Department of Anesthesiology, the Children's Hospital, Denver, Colorado. Held at Marriott Hotel, Southeast. AMA Category 1 credit available. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, Colorado 80218. Telephone: (303) 861-6949.

Nov 29-Dec 3 **Hospital Medical Staff Conference** - Clearwater Beach, Florida. Contact: Estes Park Institute, P.O. Box 400, Englewood, Colorado 80151. Telephone: (303) 761-7709.

December

3 **Neuropsychiatric Grand Rounds**; 1-3 p.m. APA approved course for Category I credit developed by Colorado State Hospital, Pueblo. Contact: James H. Scully, M.D., 1600 West 24th Street, Pueblo. (303) 543-1170. (Note: Subsequent Grand Rounds will be held January 7, 1982, February 4, 1982, March 4, 1982, April 1, 1982 and May 6, 1982).

3 **Practical Therapeutics for Physicians: 1981** - Sheraton Denver Tech Center, Denver, CO. 7 credit hours of Category I AMA-approved. Contact: Beth H. Pillar, Administrative Director of Professional Education, Rocky Mountain Drug Consultation Center, West 8th & Cherokee, Denver, CO 80204 (303) 893-DRUG.

3-5 The Sports Physical Therapy Section of the American Physical Therapy Association in association with the Medical College of Virginia School of Physical Therapy will present the 2nd Annual Combined Physician-Therapist Conference on "The Evaluation and Current Treatment of Athletic Injuries: The Lower Extremity Kinetic Chain" at the Hyuatt Regency O'Hare, Chicago, Illinois. Credit: 17 hours AMA Category 1. Contact: Ms. Kathy Johnson, Continuing Medical Education, Box 48, MCV Station, Richmond, Virginia 23298.

4-11 **Behavioral Medicine & Primary Care in the 80s** - Ilikai Hotel, Honolulu, Hawaii. Sponsored by: Professional Institutes, University of South Carolina School of Medicine. Credits: Approved for 16 hours AMA Category I credit of the Physicians Recognition Award. Approved for 16 prescribed hours by the American Academy of Family Physicians. Contact: Jeri McClain, Administrative Assistant, USC School of Medicine, Office for Academic Affairs, Columbia, South Carolina 29208. Telephone: (803) 777-7470.

9 **Regional Computerized Tomography/Neuroradiology/Ultrasound Conference**, Department of Radiology, University Hospital, Denver, Colorado 5:30 pm to 9pm, Room #2242. RSVP one week in advance. Contact: Suzanne Warner (303) 394-7774. (3 hours AMA Category I credit) This meeting is sponsored by the Department of Radiology, University Hospital & by the office of Postgraduate Education

of the University of Colorado School of Medicine.

10-12 **The Management of Patients with Burn Injuries**—Brown Palace Hotel. Contact John A. Boswick, Jr., M.D., 4200 E. 9th Avenue, Box C-309, Denver, Colorado 80262. Telephone (303) 394-8718. (18 hours AMA Category I credit).

11-13 **Cardiology for the Practicing Physician** - Woodlake Inn, Sacramento, California. Tuition: \$155.00 - Credits: 18 hours in Category I. Accreditation from the American Academy of Family Physicians is pending. CONTACT: Office of Continuing Medical Education, School of Medicine, University of California, Davis, CA 95616. (916) 752-0238 Ardi Naiswonger, Publications Representative

January

"Clinical Cytopathology for Pathologists - Postgraduate Course"—The 23rd Postgraduate Institute for Pathologists in Clinical Cytopathology is to be given at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, Baltimore, Maryland, March 22, 1982 - April 2, 1982. **Please Note: While the course is not until March, 1982, the deadline for applications is shortly after the first of January, 1982, (before 1/27/82).** Contact: John K. Frost, M. D., 610 Pathology Building, The Johns Hopkins Hospital, Baltimore, Maryland 21205.

3-8 **Ninth Annual Symposium on Clinical Echocardiography: Clinical Applications & New Developments in Cardiac Imaging** at Snowbird Ski Resort - Snowbird Conference Center, Snowbird Ski Resort, Snowbird, Utah. Contact: American College of Cardiology - Ms. Mary Anne McInerney, Director Extramural Programs Department, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

9-16 **Current Clinical & Legal Issues: The Mark, Vail, Colorado.** Contact: Beth Israel Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone (303) 629-5333; toll-free outside Colorado (800) 525-5810.

11-15 **13th Annual Cardiovascular Conference at Snowmass**: Snowmass Resort, Snowmass, Colorado. Contact: Registration Secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014. Telephone: (301) 897-5400.

11-15 **Practical Neurology for the Internist & Family Physician, Postgraduate Course** - The Given Institute, Aspen, CO. 24 hours CME Category 1 Credit. Fee: \$300.00. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, CO 80262. Phone (303) 394-5241.

13-16 **Supercourse VII - A Clinical Course on Critical Pulmonary Care**: Fairmont Hotel, New Orleans, Louisiana. Accredited by the AMA in Category I for the Physicians Recogni-

tion Award. Sponsored by the American Lung Association of Louisiana and the American Thoracic Society of Louisiana. Contact: Course Coordinator, American Lung Association of Louisiana, 333 St. Charles Avenue, Suite 500, New Orleans, La. 70130. Telephone: (504) 523-5864.

17-22 **Keystone Summit on Allergy, Immunology and Pulmonology:** Keystone, Colorado. 21 hours of AMA Category I credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital/National Asthma Center, 3800 E. Colfax Avenue, Denver, Colorado 80206. Telephone: (303) 388-4461.

17-22 **Horizons in Surgery, Postgraduate Course** - The Inn at West Vail, Vail, CO. 16 CME Category I credit hours. Fee: \$360.00. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. Phone (303) 394-5241.

18-21 **Chest Radiology** - 1981 & 1982—San Diego, CA. Contact: Mary J. Ryals, Suite 101, 10855 Sorrento Valley Road, San Diego, CA 92121. Phone (714) 452-4722.

18-21 **Chest Radiology** - 1981 & 1982—San Diego, California. Contact: Mary J. Ryals, Suite 101, 10855 Sorrento Valley Road, San Diego, California 92121. Tele: (714) 452-4722.

18-22 **Radiology for the Non-radiologist** -Innisbrook, Florida. 25 hours Category I credit. Contact: Edward A. Eikman, MD, Associate Prof. of Medicine, University of South Florida (Veterans Administration Hospital), 13000 North 30th St., Tampa, Florida 33612. Phone (813) 974-2032.

21-23 **"Topics in In-Patient Psychiatry"**—held at The Mark, Vail, Colorado. Room deposits must be made by September 20, 1981. Contact: Joanne H. Ritvo, M. D., Program Chairman, Colorado Psychiatric Society, 1555 East Lake Place, Littleton, Colorado 80121.

24-29 **Eighth Annual Midwinter Program in Continuing Education for Psychiatrists**—Hyatt Lake Tahoe, Incline Village, Nevada. Tuition: \$245.00. Credit: 24 hours in Category I. Contact: Ardi Neiswonger, Office of Continuing Medical Education, School of Medicine, University of California, Davis; Davis, CA 95616. Phone (916) 756-8162.

27 **Health in the Occupational Environment**—Julesburg, Colorado. Number of Colorado Medical Society Category I hours & AAFP prescribed credit: two. Contact: Martin J. Rubinowitz, M. D., The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

27-29 **Sixteenth Annual Vail Midwinter Cancer Seminar: "Diagnostic & Therapeutic Applications of Monoclonal Antibodies/Thyroid Cancer: Present Status."**—The Crest Resort Hotel, Vail, CO. Registration deadline: January 1, 1982. Contact: Midge Cullis, American Cancer Society, Colorado Division, Inc., 1809 E. 18th Ave., Denver, CO 80218. Phone (303) 321-2464.

27-29 **"Echocardiography: An Introduction Course for the Practicing Physician"**—Beverly Hilton Hotel, Beverly Hills, California. Contact: Ms. Mary Anne McInerney, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

30-31 **Medical Applications of Dance, Yoga, and T'ai Chi** - Houston, Texas. Michael E. DeBaKey Center, Baylor College of Medicine, Texas Medical Center, Houston, TX 77030. Duration: 1½ days. Contact: Office of Continuing Medical Education, Baylor College of Medicine (Program Coordinator, Lynn K. Tiras), Texas Medical Center, Houston, TX 77030. Phone (713) 790-4941.

Jan 31-Feb 5 **The Rocky Mountain Pediatric Radiology Seminar** - Vail, CO. Contact: Director of Professional Education, Rocky Mountain Poison Center, West 8th Ave. & Cherokee St., Denver, CO 80204. Phone (303) 893-7774. 20 Category I AMA credits.

February

6-7 **Los Angeles OB-GYN Forum** - Beverly Hilton Hotel, Beverly Hills, CA. Accreditation: CMA - 10 hrs. Category I; ACOG - 9 Cognates; AAFP - 10 elective hrs; Nurses - 10 contact hours. Contact: Director of Medical Education, L.A. OB-GYN Society, 5820 Wilshire Blvd., #500, Los Angeles, CA 90036. Phone (213) 937-5514.

6-13 **Emergency Medicine/Critical Care** at Marriott's Mark Resort, Vail, Colorado. (ACEP credit) 22 credit hours. Urology at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone: (303) 629-5333. Toll-free (800) 525-5810.

7-12 **Fifth Annual Postgraduate Course New Approaches to Clinical Problems in Internal Medicine**—Snowmass Village, Snowmass, Colorado. Presented by the Department of Medicine, University of Colorado School of Medicine. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone (303) 394-5241.

8-12 **The Denver Postgraduate Institute in Emergency Medicine: Pediatrics, OB-GYN & Surgical Subspecialties.** Contact: Janice Alexander, Denver Postgraduate Institute in Emergency Medicine, Emergency Medical Services, Denver General Hospital, West 8th & Cherokee, Denver, Colorado 80204. Telephone: (303) 893-7034

8-12 **35th Annual Meeting of the Northwestern Medical Association - Scientific/Ski Meeting.** Place: Sun Valley, Idaho. Credit: 10 CME Category I. Contact: Norman Christensen, M. D., Secretary, 2456 Buhne Street, Eureka, California 95501.

11-13 **"Perspectives on New Diagnostic & Therapeutic Techniques in Clinical**

Cardiology: Exercise Testing Post Myocardial Infarction, Radionuclide Cardiac Imaging, 2-D and 3-D Echocardiography, Coronary Artery Spasm, Calcium Channel Blockers, Coronary Angioplasty, Thrombolytic Therapy, Coronary Surgery - Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista, Florida. Contact: Mary Anne McNerny, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20041.

13-20 OB/GYN at Marriott's Mark Resort, Vail, Colorado (ACOG credit); **Psychiatry** at Lion Square Lodge, Vail; **Geriatric Medicine** at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. (303) 629-5333. Toll-free (800) 525-5810

14-19 Eighth Annual Winter Skin Seminar—The Given Institute of Pathobiology, Aspen, Colorado. Contact: The Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone: (303) 394-5241

18-20 "Nuclear Medicine For Physicians and Technologists"—San Diego, California. Contact: San Diego Radiology Research & Education Foundation, P. O. Box 2305, LaJolla, CA. 92038. Telephone (714) 453-7500, ext. 3711

22-27 28th Annual Family Practice Review - Postgraduate Course—40 hours CME Category I credit. Fee: \$315.00. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO. 80262. Phone (303) 394-5241.

23-27 Bedside Approach to Cardiac Diagnosis - Keystone, Colorado. Sponsored by Rose Medical Center. Category I credit & AAFP prescribed credit offered. Fees: \$365.00. Information: Dorothy Bailey, Office of Education, Rose Medical Center, 4567 E. 9th Ave., Denver, CO 80220. Phone (303) 320-2102.

26-28 Extra Extracapsular Cataract & Anterior & Posterior Intraocular Lens Implant Course. Place: The Waiohai Hotel, Kauai, Hawaii. Course Director: David S. Pfoff, MD. Fee: \$700.00 for didactic & lab; \$400.00 for didactic only. Contact: Colleen Requist, c/o Dr. Pfoff's office, 950 E. Harvard Ave., Suite 350, Denver, CO. 80210. Phone (303) 777-5457.

26-28 Tenth Annual Taos Lung Disease Symposium - Kachina Lodge, Taos, NM. Contact: New Mexico Chapter of the American Thoracic Society, 216 Truman NE, Albuquerque, NM. 87108. Phone (505) 265-0732.

Feb 27-Mar 7 Cancer Treatment - at Kiandra Lodge, Vail, CO.—Sports Medicine at Lion Square Lodge, Vail, CO. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO 80211. Phone (303) 629-5333; (800) 525-5810.

Feb 28-Mar 5 Infectious Diseases and

Rheumatology Course - The Given Institute, Aspen, CO. Category I and AAFP Prescribed credit. Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Denver, CO 80262. Phone (303) 394-5241 or 5195.

March 1982

2-5 35th Annual Symposium on Fundamental Cancer Research "Perspectives on Genes & the Molecular Biology of Cancer."—Shamrock Hilton Hotel, Houston, TX. Information: Stephen C. Stuyck, Director, Public Information & Education, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Ave., Houston, TX 77030. Phone (713) 792-3030.

4-6 Third Annual Radiologic Technologists Course - San Diego, CA. Contact: San Diego Radiology Research & Education Foundation, P.O. Box 2305, LaJolla, CA 92038. Phone: (714) 453-7500, ext. 3711.

6-13 Family Practice at Marriott's Mark Resort, Vail, CO.—General Surgery at Lion Square Lodge, Vail—**General Dentistry** at Kiandra Lodge, Vail (AGD & ADA credit). Contact: Beth Israel, Conference Program, Box 11366, Denver, CO 80211. Phone (303) 629,5333, (800) 525-5810.

8-10 Gastroenterology for Clinicians - Learning in the Sun—Scottsdale, Arizona. AMA Category I and AAFP credit - 16½ hours. Contact: Mrs. David C. H. Sun, David C. H. Sun Memorial Institute, 4129 E. Sandy Mt. Road, Scottsdale, ARIZ. 85253. Phone: (602) 948-1064.

8-12 High Risk Infant Care - Postgraduate Course - Denver, Colorado. 34 Category I credit hours with 6 additional hours credit available for workshops. Fee: \$300.00 plus \$75.00 for workshops. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. Phone (303) 394-5241.

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Frederic C. Hewlette, MD, died on Thursday, October 8, 1981, at University Hospital. Dr. Hewlette, 59, was director of the heart station at Mercy Medical Center. He was born December 23, 1921, in New York City. He attended Queens College and the University of Geneva, was a fellow of cardiology at University Hospital, National Jewish Hospital and St Joseph Hospital of Syracuse, N.Y. Dr. Hewlette belonged to the Internal Medicine Society, Society of Cardiovascular Medicine, Catholic Physician Guild, and the Denver and Colorado Medical Societies.

Survivors include his wife Sheryl, daughter Stacey, and son Mark, all of Denver. His mother, sister, and two brothers also survive.

Gordon A. Munro, MD, 55, of Grand Junction, Colorado, died on October 9, 1981, after a long illness. Born in Grand Junction on March 4, 1926, Dr. Munro attended the University of Colorado for his B.S. degree. He then spent four years in the U. S. Navy, following which he attended Washington University School of Medicine in St. Louis, receiving his MD degree in 1949.

Munro returned to Colorado that year, serving a one-year internship at Colorado General Hospital. He began his five-year postgraduate training as surgical resident at the University of Colorado Medical Center. His private-practice career was again interrupted to serve two years in the Far East Command of the U.S. Army Medical Service during the Korean War. He then completed his residency training after his military discharge, becoming chief

surgical resident at the C. U. Medical Center.

Dr. Munro returned to Grand Junction in 1957 to join his father, the late Dr. E. H. Munro, in surgical practice. He served as chief of the surgical section at St. Mary's Hospital on two different occasions. He served as president of the Mesa County Medical Society and had numerous other affiliations in both medical and public associations and organizations. Dr. Munro is survived by his wife, Georgia Lou, two daughters, a son, his mother and a sister.

Millard Franklin Schafer, MD, of Colorado Springs, died Friday, October 9, 1981, at the age of 83. Dr. Schafer moved to Colorado Springs in 1941, established a medical practice and administered a city-county health unit. He was the first full-time health officer in El Paso County. Born January 12, 1898, in Buckley, Illinois, Schafer attended the University of Nebraska in Omaha, and received his medical degree from the University in 1924.

Dr. Schafer was president of the Colorado Public Health Association in 1945, and a board member of the El Paso County Chapter of the Tuberculosis Association. He also belonged to the El Paso County Chapter of the National Foundation for Infantile Paralysis and was a charter member of the American Association of Public Health Physicians.

James M. Shields, MD, of Denver, died on September 7, 1981 at the age of 100. Dr. Shields was born November 2, 1880, in Washington,


Iowa. Shields most recently was a resident of the Montclair Manor in Denver.

Shields graduated from the University of Iowa and Jefferson Medical College in Philadelphia. He served in the U.S. Army Medical Corps during World War I and was a professor of ophthalmology for 25 years at the University of Colorado. In addition to membership in the Denver and Colorado Medical Societies, Dr. Shields was a member of the American Medical Association, the American College of Surgeons, the American Academy of Ophthalmology and the Denver Clinical and Pathological Society.

Dr. Shields is survived by a daughter, Josephine Creel of Denver, six grandchildren and eight great-grandchildren.

Myron Wilkoff, MD, former chief of staff of Lutheran Medical Center, died Saturday, October 10, 1981, in Denver. Dr. Wilkoff was born January 9, 1909, in Youngstown Ohio. After graduating from the University of Colorado School of Medicine in 1936, he did postgraduate medical residencies at the University of Pennsylvania and Charleston, W. Va. General Hospital. His medical practice in Denver spanned more than 45 years.

Dr. Wilkoff was founder and first president of Rodef Shalom Synagogue. He and his wife, Frieda, celebrated their 50th wedding anniversary in September. Mrs. Wilkoff survives, as well as a daughter, Ann Jacobsen of Littleton; a son, Robert Wilkoff of Anaheim, California; two brothers, and four grandchildren.



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CALIFORNIA: Director positions available emergency medicine physicians needed for rural California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610, (415)832-6400. 381-1-TFN

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PEDIATRICIAN: Colorado Springs -Associate desired: Fun, active practice. CONTACT: Peter J. Adasek, M.D., FAAP, 2512 N. Cascade Ave., Colorado Springs, Colorado 80907. CALL: (303) 473-6100 DAYTIME, (303) 687-2621 EVENINGS. 881-25-3B

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CERTIFIED FAMILY NURSE PRACTITIONER: (also certified as Physician Assistant) with extensive clinical and practice management experience seeks position with physician or group of physicians in the Denver metropolitan area. Will work to fill your needs whether they be in the clinical or administrative area or a combination of both. Experience is primarily in Family Practice, Emergency Medicine, General Surgery and Gynecology but I am willing to work in other specialty areas if physician is willing to teach. Salary, hours, benefits negotiable. CV and references available upon request. **Phone:** (303) 477-6893 or address inquiries to 4636 West 26th Avenue., Denver, Colorado 80212. 1081-6-1b

PHYSICIAN, Board Certified in radiation, oncology and diagnostic radiology; and spouse, trained in medical oncology; looking for relocation. **CONTACT:** Howard McCollister, MD, University of Nebraska Medical Center, Department of Surgery, 42nd and Dewey Avenue, Omaha, Nebraska 68105. **CALL:** (402) 559-4075. 1081/5/3b

NATIONALLY CERTIFIED PHYSICIAN assistant with two years experience in family practice, including one year at primary care and emergency facility in Kiowa, Colorado under remote physician supervision seeks employment in general or family practice anywhere in Colorado. Resume' upon request. **CONTACT:** JOHN CAIN, BOX 303, Kiowa, Co. 80117 981-21-1b

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FOR LEASE: Medical office space, Lakewood, new building with laboratory, x-ray, and pharmacy, with excellent referrals. Some large and some small suites still available. Lakewood Medical Center, Inc. (303) 779-6721. 181-1-1b

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Doctor: What you can't do alone, we can do together!



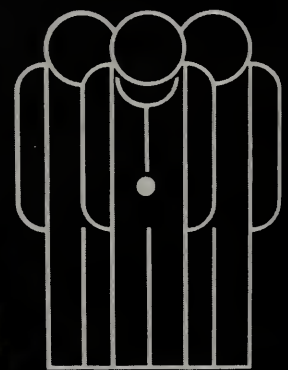
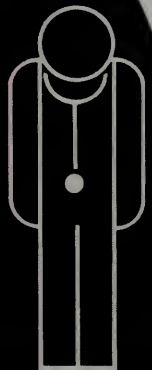
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| EDITOR (Name and Complete Mailing Address) <i>William S. Pierson, Executive Director, Communications, Colorado Medical Society 1601 E. 19th Avenue, Denver, Colorado 80218</i> | | |
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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyoderms (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

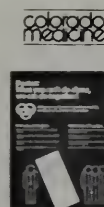
When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Cover Story:

The cover says it all: a new thrust for county, state and AMA membership, working together for organized medicine. The cover is a reproduction of the newest AMA poster for hospital and clinic staff rooms, seeking

total support for organized medicine on the local and national level. The message is there: "Doctor, what you can't do alone, we can do together." This magazine reaches those concerned and participating doctors who already support their professional association, so the task is obvious: You must take the message to your colleagues who do not presently belong to a local component of the CMS or the AMA. Make them aware of the values of association membership and participation. There is much more that can be done as a total organization, nationally, which cannot be done on an individual basis. Carry the message! Get involved! Get others involved!

articles

427 Economical Gonorrhea Control in Colorado

by John J. Potterat, B.A., Director of V.D. Control, El Paso County Health Department, and

John B. Muth, M.D., Medical Director, El Paso County Health Department, Colorado Springs, Colorado

An overview of the subject asks the question, "Is it necessary to control gonorrhea?" This would certainly seem to be contrary to the usual social perception of a "dreaded" disease. But how much of the perception is "social" as opposed to "clinical?" This new study may give valuable insight into putting gonorrhea into its proper medical perspective.

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407 **Hall of Life Receives \$56,000 Gift From AMA:** reorganization of AMA brings end to traveling health education exhibits. and Denver's Hall of Life becomes the beneficiary in its newly-completed classrooms and exhibit space.

407 **Rocky Mountain Drug Consultation Center Receives National Award:** consumer education program from RMDCC judged among the best, nationally.

417 **COCHEMS Trust Fund:** CMS fund is still available for member physicians who are in need of financial aid.

417 **Your Vitae, That Important First Impression:** have you checked up on your own curriculum vitae recently? Here are some practical steps to making your CV most effective.

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president's letter

Mr. Michael Vitek
President Colorado State Board of
Medical Examiners
1525 Sherman St.
Denver, Colorado 800203

Dear Mr. Vitek:

During our telephone conversation on October 27, 1981, it was my understanding that you stated the Board of Medical Examiners had the discretionary authority to decide whether or not the names of the physicians on probation in the state of Colorado should be released to the press. The BME decided to release the names and subsequently they were published in the *Denver Post* on October 25, 1981. You also said that this decision could be reviewed at the next meeting of the BME and, conceivably, reversed.

Since the publication of these physicians' names, I have been contacted by a significant number of physicians around the state and, without exception, they were quite disturbed by this breach of confidentiality.

The physicians I have talked to agree that when a physician loses his license, as a result of aberrant or illegal behavior, this fact should become public knowledge and there is no reason why it should not be publicized by the press, if they so desire. However, in cases in which the physician is placed on probation and the goal is to rehabilitate the physician so that he/she may return

to the unfettered practice of medicine, the publication of the physicians' names is undoubtedly detrimental to this goal. As a matter of fact it is probably impractical to attempt to rehabilitate any physician without some attempt to protect his confidentiality. Therefore, it is our view that this new policy of the BME will effectively sabotage any rehabilitation program.

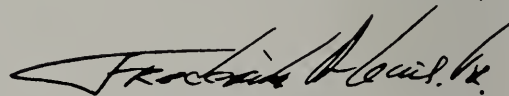
It will also effectively discourage physicians who need help from seeking it and will encourage physicians to fight legally all efforts by the BME to place them on probationary

status. This will further complicate the BME's resources so far as attorney's time is concerned.

I would like to make it clear that the CMS in no way condones the inferior practice of medicine and, as you know, the CMS has, in the past, fully supported the BME in its efforts to discipline errant physicians.

However, this recent decision by the BME is going to make life more complicated for both organizations and I would like to respectfully request that the BME reverse its decision at its next meeting. We would much prefer to continue to work with the BME in a cooperative and harmonious fashion and attempt to rehabilitate errant physicians so that they can once again become useful, contributing members of society.

Sincerely,



Frederick A. Lewis, Jr., M.D.
President



Rehabilitation Groups of the American Cancer Society

Reach to Recovery

Reach to Recovery is a rehabilitation program for women who have had breast surgery. It is designed to help them meet their physical, psychological, and cosmetic needs. Volunteers, who have been selected by their doctors and have completed training, visit patients in the hospital with the physician's approval. No medical advice is given but compassion and emotional support are available.

For more information,

American Cancer Society
Colorado Division, Inc.
321-2464

Rocky Mountain Drug Consultation Center of Denver Receives National Award

The Rocky Mountain Drug Consultation Center of Denver General Hospital has received national award recognition for its program of *Drug Information for Consumers and Health Professionals*.

The American Society of Hospital Pharmacists has named the Denver Center as winner of the 1981 Award for Achievement in the Professional Practice of Hospital Pharmacy. The yearly award is based on programs of drug information services to consumers and professionals and prevention of medication misuse, such programs having been published in the *American Journal of Hospital Pharmacy*. The ASHP is the largest professional pharmacy association in the United States. The award will be presented to Christopher S. Conner, Pharm. D., Director of the Rocky Mountain Drug Consultation Center. A bi-monthly report from RMDCC appears in *Colorado Medicine*, concerning current questions and answers about medication.

Call For Papers for the Nineteenth Annual Rocky Mountain Bioengineering Symposium

Sponsored by the University of Colorado Health Sciences Center

Papers are being solicited for the 19th RMBS program to be held April 19-20, 1982, at the Landmark Inn of Denver.

The RMBS has been held each year since 1964 at sites in and around the Rocky Mountain area. Although considered to be a regional conference, contributions come from all parts of the U.S. Accepted papers will be published in the nationally distributed Conference Proceedings. In addition, abstracts will appear in the IEEE Transactions on Biomedical

Engineering, and selected full papers will appear in the ISA Transactions.

Technical sessions proposed are:

- Biomedical Instrumentation
- Health Care Delivery Systems
- Imaging Systems
- Computer Applications in Medicine
- Ultrasound Instrumentation
- Instrumentation in Wildlife Management
- Clinical Engineering

Deadline Dates: Receipt of Abstracts by November 15, 1981; Notification of Acceptance by January 1, 1982; Receipt of Completed Paper, February 1, 1982. An abstract, not to exceed 200 words (double-spaced) typed, should be submitted to:

K. C. Rock, P.E.,
Director of Bioengineering
University of Colorado Health
Sciences Center
4200 East 9th Avenue (A056)
Denver, Colorado 80262
(303) 394-8351.

The abstract should describe the problem investigated, methods used and results obtained. Work-in-progress reports are discouraged. Completed manuscripts must be supplied by RMBS to the printer by February 15, 1982.

Very Low Calorie Diets Pose Significant Health Hazard

Physicians attending the 31st Annual Obesity & Associated Conditions Symposium sponsored by the American Society of Bariatric Physicians, October 15-18, issued a strong warning to dieters on very low calorie programs without medical supervision. The ASBP position statement was adopted because of fears that the improper or totally non-existent medical supervision of such very low calorie programs may result in a rash of deaths similar to the 1977 "liquid protein" diet deaths. The ASBP statement, which was adopted unanimously by members present, states:

It is the official position of the American Society of Bariatric Physicians that very low calorie diets (in-

cluding instant mix formulas and premixed liquid preparations) pose a significant health hazard to dieters, not under continuous and immediate medical supervision by a physician knowledgeable in the metabolism and nutrition of such diets. Such supervision includes appropriate laboratory evaluation at regular intervals.

In 1976 a similar warning was released regarding the unsupervised or inadequately supervised administration of protein sparing modified fast programs. The following year, the so-called "liquid protein" diets deaths were reported by the FDA.

AMA Contributes \$56,000 in exhibits to Denver's Hall of Life

Traveling Exhibits Find Permanent Home in Denver Health Education

With reorganization of the American Medical Association during the year some of the services previously delivered by the AMA have been discontinued. One of those was the traveling health education exhibits which have been available for display in schools and other public places. Because of the rapidly increasing costs of transportation, repair and maintenance of the large, animated exhibits, it was found to be an unwieldy project for the AMA Health Education Division to continue.

The exhibits, consisting of a variety of body functions shown through numerous, large modular display units, have been traveling the country for a number of years, being displayed for six-month intervals in a wide variety of settings. Persons or agencies wishing to request use of the displays did so by contacting the AMA offices and agreeing to pay shipping costs for the displays. Typical of the popular displays is the "Life Begins" module, which consists of the human embryo from its inception to just prior to birth, each encased in transparent plastic, effectively lighted and explained in the standing panels. This exhibit was one of a number designed and built

(Continued on next page.)

(Continued from previous page.)

by the Richard Rush Studios of Chicago, Illinois, foremost in such educational exhibit production.

The Hall of Life, located at 700 Broadway in Denver, has used the AMA exhibits on more than one occasion in its short history, and was seeking such exhibits for permanent display. Upon learning that the AMA was going to discontinue its traveling exhibits, the Hall of Life requested that AMA abandon the exhibits in Denver, donating them to continuing health education in the Hall of Life. Not all of the exhibits were left to the Hall of Life; however, the AMA Board of Trustees authorized donation of five exhibits, "Life Begins," "We See," "We Hear," "How We Breathe," and "Your Brain." Even considering the age and use of some of the exhibits, their effectiveness makes them extremely difficult to replace, and a conservative replacement value of \$56,000 was affixed to the gift. More important than the dollar value of replacement is the fact that the Hall of Life was able to use this gift as an offset to a challenge grant by the Boettcher Foundation of Denver for \$75,000 toward construction of additional exhibits.

The Hall of Life is now in its fifth year, but has just held its grand opening ceremonies, noting the completion of four separate theatre-style classrooms, having already had over 8,000 persons through its classes in 1981. The classroom construction, decorating and equipping (except for the exhibits) was a donation by the Heggem Lundstrum Paint Company of Denver. Many other Denver-area firms have contributed

to the equipping of the classrooms and exhibit areas. The Hall of Life has a staff of highly qualified health education experts and its popularity has grown weekly, with young people who are genuinely interested in their own health and health education. The Hall of Life, however, does not limit its health education facilities to any age group. Adults of all ages as well as school-age children visit the Hall of Life.



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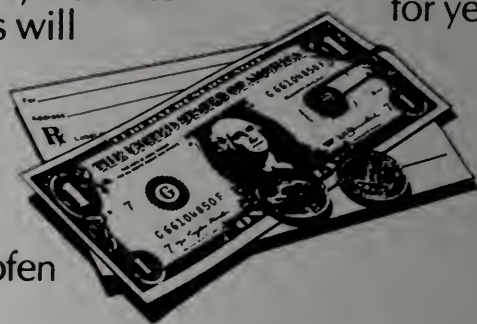
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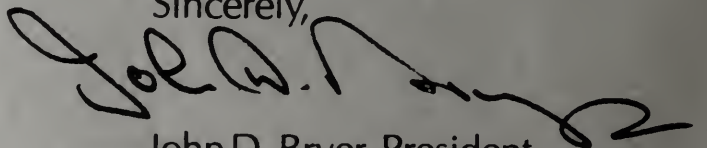
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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecostasia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

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874-7681, Ext 203

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565-3713

HIGHLIGHTS OF CMS BOARD MEETING

Condensed Minutes, Board of Directors Meeting
November 13, 1981, Denver, Colorado

1. Board members were informed that \$7,275 in Interest Income from the Cochems Trust Fund is available for distribution prior to December 31, 1981.

2. Board members were informed that the Prospectus would be mailed to all CMS members the week of November 16. The Board approved accepting all subscriptions to purchase CMS Headquarters property from any physician in the state until December 3. Following that date purchases up to two million dollars will be accepted; after that date they will be returned.

3. Adopted a Resolution recommending that a Physician's Captive Insurance Company be established and that application be made to the Colorado Commissioner of Insurance as soon as possible.

4. Approved the Hilton Inn South as the location for the 1982 Interim Meeting to be held March 6-7, 1982

5. Approved actions of the Council on Legislation:

a) Request the Council on Professional Relations and Medical Service study guidelines developed by the National Council on Medical Specialty Societies and determine the feasibility of writing and structuring a bill concerning physician's assistants.

b) CMS support a bill mandating a catastrophic rider on all insurance policies and catastrophic insurance for the medically indigent.

c) CMS continue its concern with health needs of the medically indigent which do not come within the definition of "catastrophic illness."

d) Organize a trip to Washington, D. C. in the spring of 1982 for physicians and families to view the federal legislative process, first-hand.

CMS PRESIDENT MOVES TO CHANGE BME POLICY OF PUBLISHING THE NAMES OF IMPAIRED PHYSICIANS IN COLORADO

CMS President Frederick A. Lewis, Jr., M.D., has notified the President of the Colorado Board of

Medical Examiners that the BME's policy on releasing the names of those physicians who are in any rehabilitative program will effectively sabotage the rehabilitation attempts.

Dr. Lewis wrote the strongly-worded letter following the publication by the Denver Post of names of 25 physicians who are currently on probation. The Post, by the way, headlined the report "names, dates and causes of doctors' suspensions," which is not the case. The doctors ARE on PROBATION and, in most cases, are volunteers in the rehabilitation program. Dr. Lewis pointed out that the CMS membership agrees that if a physician loses his license as a result of aberrant or illegal behavior, the fact should be made public. However, Dr. Lewis said, publicizing the names of physicians who have been placed on probation and who are attempting to accomplish a rehabilitation to return to an unfettered practice is "undoubtedly detrimental to this goal."

(EDITOR'S NOTE:) Dr. Lewis' letter, written to the Board of Medical Examiners, is reprinted in the "President's Letter" of this issue.

PUBLIC INFORMATION COMMITTEE MOVES TO TAKE PRESS COVERAGE OF PROBATIONARY PHYSICIANS TO GRIEVANCE COMMITTEE

The CMS Public Information Committee Chairman, Robert A. O'Dell, M.D., stated that the Colorado Medical Society should consider a grievance procedure through the Colorado Code of Cooperation concerning the false and misleading reporting of the names of those physicians on probation, whose names were included in the list of alleged "suspended" doctors. The P. I. Committee will forward this proposal to the CMS Board for consideration.

CMS PROFESSIONAL LIABILITY TRUST IS IN "EXCELLENT HEALTH," BUT STILL NEEDS (YOUR) THE DOCTOR'S CARE!

Numbers indicate that more than 60% of those members who participate in The Hartford program of professional liability insurance are signing up for the CMS Professional Liability Trust at renewal time.

The Trust is "up and running," but it still needs support of as many physicians as possible. Members can join the Trust at any time, and this does not effect the member's present program in any way. Those who join the Trust now won't even have to pay any up front you will be billed for the \$100. And the \$100 is not an add-on or any additional premium payment; it is merely earnest money which is a part of your first premium payment toward renewal of your present insurance program. REMEMBER TOO: the Trust is an integral part of The Hartford program now in force, but the Trust is the first major step in self direction for doctors of Colorado, and membership in the Trust is necessary to CMS being able to influence

premium levels. Get your Trust application In TODAY!

NOTE FROM THE CMS HISTORIAN: "HELP! HELP! HELP!"

(From James J. Delaney, M.D., Historian, Colorado Medical Society)

"The archival material of the Colorado Medical Society is in a sad state of disarray. I need help in cataloging and collating the material before the Society moves to new quarters. Unless this is done, I am sure that valuable material will be lost in the move. Are there any members of CMS, the Auxiliary or their families with an interest in archival material who would be willing to help? Any time would be appreciated: a few minutes, an hour or two, a day, any time --- weekly, monthly---anything! If you would like to help, please call me at 341-6450, or contact Virginia Bell at CMS, 861-1221."

CMS HEADQUARTERS PROPERTY PROSPECTUS IS MAILED!

The CMS Building Project is moving positively. CMS Building Committee has reported that a Prospectus concerning purchase of CMS Headquarters property would be (or has been) mailed to all members OF CMS within a matter of days after the November Board meeting. It is the understanding of the COLORADO MEDICINE editor that the Prospectus was mailed during the week of November 16th, and that the mailing would continue into the week of November 23rd.

Members of the Building Committee have been considering the details of land purchase and of necessities created by the interim between construction of a building and having to move from the present location. This means finding interim quarters for CMS and CFMC offices for a period of anywhere from 6-9 months to two years. The consideration of available properties continues.

IMPAIRED HEALTH CARE PROFESSIONALS BECOMES THE SUBJECT OF NATIONAL STUDY.

Physicians, nurses, hospital administrators, attorneys, social workers, and other concerned about impaired health care professionals have been invited to attend a one-day conference to study and meet the challenge to the professions.

Stated purpose of the conference, being sponsored by the American Society of Law and Medicine, is to identify the types of impairment and their impact upon patient care, health care institutions, other health care professionals, the impaired professional and his or her family. The conference will also strive to identify the causes of impairment and the means to recognize behavior indicating impairment. The conference directors also hope to point up the various approaches being followed by a number of professions to treat and detect impairment and clarify the legal implications of impairment to the patient, the institution, other health care providers and the impaired professional.

The fee for the conference, to be held at the Detroit Plaza Hotel, Renaissance Center, on March 5, 1982, is \$65 for non-members, and \$30 for students.

IATROS FOCUSES MEETING ON RESISTANCE TO GOVERNMENT CONTROL AND REGULATION OF MEDICAL CARE

A meeting of the IATROS Society (International Organisation of Private and Independent Doctors) will be held March 5 through 10, 1982, in Charleston, South Carolina. The meeting will be devoted to "the promotion of the private practice of medicine and resistance to government control and regulation of medical care."

Speakers will include IATROS regional representatives from Europe and Australia as well as the U.S., and prominent leaders in medicine, politics and journalism. Among these is Dr. Curtis Calne, President, Association of American Physicians and Surgeons, Dr. Francis Davis, Publisher: "Private Practice," and columnist and TV commentator James J. Kilpatrick.

For information, contact: IATROS, 63 Gadsden Street, Charleston, S.C. 29401.

AIR TRAVEL DIFFICULTIES POINTED OUT IN THE WAKE OF THE ATC STRIKE

For any of you planning to travel for vacations, business, or to meetings, it is wise to plan well in advance of your departure, if your trip includes travel by air. The Air Traffic Controller's strike has intensified the difficulties of travel, and demands that you make your plans as far in advance as possible. Even then, you may encounter long waits, some inability to get the scheduled flight of your choice, etc.

Consult your travel agent about special fares, planning a flexible schedule around these flights, and alternatives. Avoid making changes in your plans unless absolutely necessary, as alterations will invalidate many special rates and reservations.

ADDITIONAL NOTE

Dr. George Sheehan, Cardiologist, said:

"Most of the things we do in life have purpose but not meaning. Play is directly the opposite: It has no purpose, but it gives meaning to life."

American Association of Medical Assistants, Inc.

Colorado Society — Capitol Chapter

“Child Abuse — Our Responsibility”

Saturday, January 9, 1982

9:00 am - 2:00 pm

Humphreys Auditorium

University of Colorado

Health Sciences Center

Speakers: • John Sheppard, Investigator, Arapahoe County Sheriff's Department
• Ed Nelson, Sheriff, Arapahoe County

8:30 am - 9:30 am.....Registration
9:00 am - 11:00 am.....Speaker
11:00 am- 12:00 Noon.....Luncheon Break
(A BOX LUNCH WILL BE SERVED)
12:00 Noon - 2:00 pm.....Speaker

Continuing Education Unit credit has been applied for. Registration Costs: \$20.00 members, \$25.00 non-members. Registration costs include box lunch. Those attending who wish to have CEU credit will be charged \$2.00 for members and \$3.00 for non-members for CEU registration.

Make checks payable to: Capitol Chapter Colorado Society of Medical Assistants

Mail registration to:
Boni Bruntz CMA-A
13641 East Dakota Ave.
Aurora, Colorado 80012
Home phone: 343-0163
Office: 761-2870

Registration Form

AAMA Colorado Society, Capitol Chapter — “Child Abuse: Our Responsibility”

Name _____ Member ☐ Non-member ☐

Address _____ Zip Code _____

Home Phone _____ Work Phone _____

Social Security No. _____

Registration Deadline January 6, 1982

COCHEMS Trust Fund to Aid Doctors with Emergency Financial Needs

The Colorado Medical Society has been informed by the Trust Officer of the COCHEMS Trust Fund that certain undistributed income of the Fund is available for distribution prior to December 31, 1981.

As you may recall, this COCHEMS Trust Fund is available to medical doctors in need of emergency financial aid. However, to be eligible for such assistance, the following requirements must be met:

Physicians applying must be:

- 1) a member of the Colorado Medical Society;
- 2) a medical doctor licensed in the State of Colorado;
- 3) a resident of the State of Colorado for the past ten years;
- 4) able to supply the Colorado Medical Society with two letters from physicians within the geographical area or the component

society (the letters should briefly explain the physician's background and the circumstance(s) or reason(s) that the physician should receive financial support from the COCHEMS Trust Fund). These letters must have been received by CMS prior to any consideration of the assistance.

CMS urges each component society to advise its membership of this information. If you are aware of a physician who might qualify for this assistance, please contact Mr. Chris Stein, Executive Director of Finance & Operations, Colorado Medical Society.

50 Year Graduates: Know Anyone Who Qualifies?

The AMA's Fifty Year Club of American Medicine is planning a Mid-year luncheon for Tuesday, December 8, 1981, in Las Vegas, Nevada. The luncheon will be held during the AMA Interim Meeting. Luncheon tickets are \$15; non-

members are welcome to join the Club—annual dues are \$10. Membership is restricted to physicians graduated from medical school 50 or more years ago. To make reservations, please contact:

Mr. William Riede
AMA/Fifty year Club
535 North Dearborn Street
Chicago, Illinois 60610
(312) 751-6469

Your Vitae, That Important First Impression

American Medical Association
Physician's Placement Service

When was the last time you took a good look at your curriculum vitae (CV)? Competition for desirable practice opportunities is intense, and a professional-looking CV can mean the difference between "getting your foot in the door" or a polite brush-off. A critical review of your CV now will
(Continued on next page.)

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(Continued from previous page.)

be an important investment in your future.

A poorly constructed CV will create a negative first impression, and you will rarely have an opportunity to overcome a bad start. Your CV is really a personal advertisement: it must sell as well as tell. The appearance and format of your CV is as important as the information it contains. No matter how talented you are or how well you fit the job specifications, a disorderly or flamboyant CV will stop a potential interview in its tracks.

Following are some tips to assist you in preparing your CV. They are suggested as a general guide, as each physician's CV will be somewhat different depending on age, experience, and other unique considerations.

Format and Content

Included at the end of this article is an example of the form your CV should take. It tells who you are, it summarizes your experience and qualifications, and it reveals personal information and special talents and skills.

You should provide both home and office/hospital addresses and telephone numbers. You will want to make it easy for potential employers to reach you during *their* business hours.

When listing your educational background and practice experience, it is preferred that you begin with the most recent experience and work backward. This makes the CV much easier to read.

Include academic and professional appointments, fellowships, and other unique training experiences. Also mention if you have special expertise in a certain medical procedure, administrative experience, fluency in a foreign language, etc.

When listing the above points, do not go into great detail, as this tends to clutter and lengthen the CV unnecessarily.

What not to include

The following should never be included in your CV: race; religion; anticipated compensation; reasons for leaving previous positions; personal health problems or disabilities; examination scores; and license

and DEA numbers (those could be used by an impostor). It is also permissible to eliminate references to your age, place of birth, citizenship, and marital status. Discussion of these and other personal topics is best saved for the personal interview.

Length

The length of your CV will, of course, depend upon your age and experience. A lengthy and cluttered CV is difficult to read and may not be appropriate for your immediate needs—that of obtaining an employment interview.

Many experienced professionals prepare two CVs: a brief CV of one or two pages in length which describes the essential elements of their training, experience, and capabilities; and another CV which elaborates on all the above points and which includes an extensive bibliography, descriptions of inventions, etc. The shorter CV can be sent to a prospective employer at the time of your initial inquiry. The longer CV can be provided at (or just before) the personal interview.

Printing your CV

Your CV should be printed with black ink on good quality 8½ X 11" paper. White is the most preferable, but a subdued color shade, such as beige, is also acceptable. Reproduction by the offset printing method by a commercial printing service is desirable and will greatly enhance the professional appearance of your CV. However, if you must type your CV, be sure to use a very good quality of paper, and use a good electric typewriter. Never type your CV on hospital or university letterhead, and avoid photocopying on a poor quality duplicator.

Commercial Resume Services

These services are probably available in your area, and some universities provide this service for alumnae. These firms typically offer two kinds of services. One is an elaborate and expensive consultation and analysis of your background and career aspirations. The other kind is simply a typing and/or printing service.

If you utilize one of these services to prepare your CV for you, be sure they are sensitive to your needs and

that they understand the uniqueness of a physician's educational background, career paths, etc. Otherwise, your CV will be prepared in the same manner as an engineer, computer programmer, or advertising executive.

Cover Letters

Your CV should *never* be sent to a potential employer without a cover letter. The letter should be brief and can express your interest in learning more about the opening. The cover letter is also a good place to describe your good points, your career aspirations, and to expand on a few key areas of your CV. It can include personal information which is not included on your CV, such as temporary phone numbers, when you would be available for an interview, etc.

A cover letter should always be personalized to the potential employer. It shows that you are interested in that particular practice opportunity and avoids the impression that you are simply blanketing the market with a flurry of resumes.

References

It is preferable to state on your CV that references will be furnished on request. This protects your references from being inconvenienced by many unsolicited calls. You will want to evaluate a potential practice opportunity before you release the names of your references. Also, be sure to inform those whom you would like to act as references that you are seeking a new practice opportunity and would like to use their names. It would create a very negative impression if one of your medical school professors (whom you have not seen in years) could not remember you.

When to Update Your CV

Your CV should be completely rewritten and printed when you have completed another "milestone" in your career, when you move or obtain a new position, when you have published additional papers or books, etc. Never make handwritten comments on your CV or scratch out old information. This looks very sloppy and unprofessional.

In Summary

A CV is not simply a

chronological summary of your life. It is a tool to be used to obtain a satisfying and rewarding career. In addition, it will also lift your spirits to see your past accomplishments and future objectives put down on paper in print!

Suggested Physician Curriculum Vitae

Name:

Address:
(home and office/hospital)

Certification and Licensure:
(For example: Board Certified in Internal Medicine, September, 1978; or Diplomate, National Board of Medical Examiners, July, 1978, etc.)

Education:
(List in descending order, with the most recent first, noting name of university, degree received, and dates)

Postgraduate Training:
(List all training, such as internship, residency, fellowships, etc., with name of institutions and dates)

Practice Experience:
(List in descending order, with most

recent listed first)

Professional or Teaching Appointments:

Awards and Honors:

Professional Society Memberships:

Personal Data:
(If desired, date and place of birth, citizenship, marital status, languages spoken, etc.)

Personal and Professional References:
Furnished on Request.

Bibliography:

Grievance of the Month

Complaint:

Mary XXX writes the Grievance Committee complaining that Dr. YYY has refused to transfer her children's records to her new M.D.

Investigation:

Mary XXX, recently divorced, has moved to a new community and needs her children's immunization records to keep them in their Day Care facility. Her former husband has not paid a bill owed Dr. YYY. Dr. YYY is refusing to release the records until the bill is paid.

Disposition:

Dr. YYY is instructed by the Grievance Committee to send the records. According to AMA ethics it is unethical for a physician who formerly treated a patient to refuse for any reason to make his records of that patient promptly available to another physician presently treating that patient.

from the desk of:
WILLIAM CLARK, CPA

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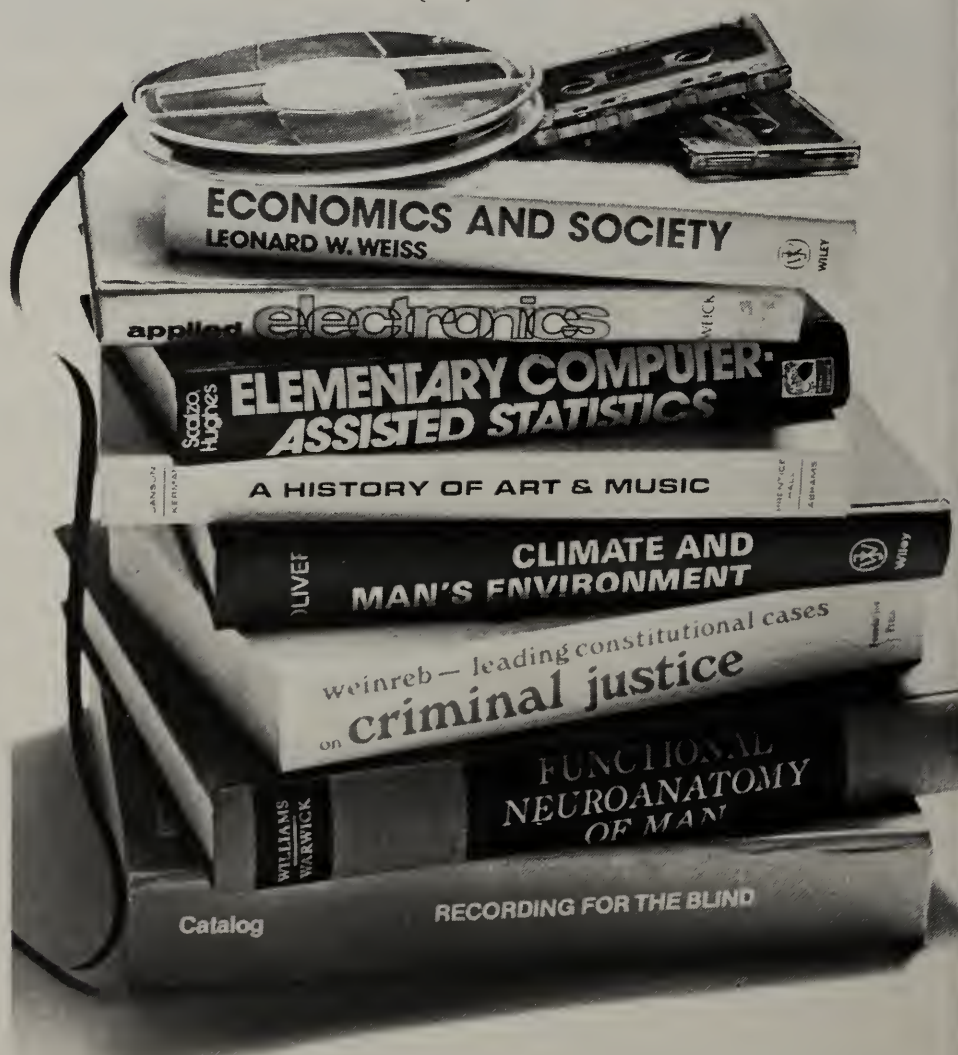
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Economical Gonorrhea Control in Colorado

John J. Potterat, BA, Director of V.D. Control, El Paso County Health Department,
and John B. Muth, MD, Medical Director, El Paso County Health Department, Colorado Springs, Colorado

Gonorrhea in Colorado is neither pandemic nor epidemic. It is hyperendemic, particularly in our large metropolitan areas. Efforts to reduce this burden may be impaired by the proposed withdrawal of direct federal support for gonorrhea control. The "block grant" mechanism advocated by the Reagan Administration is viewed with apprehension since competition in the funding of health programs may be rigorous.

A mood of pessimism, borne of this political turbulence, currently clouds public health circles. It obscures our opportunities. In the near future members of the Colorado medical community, public and private, will be queried by legislative bodies concerning the relative importance of public health programs. Opportunities for reduction of gonorrhea incidence and its complications are available; our aim is to present the case for economical gonorrhea control.

An Overview

Is it necessary to control gonorrhea? Startling as this question may be, we ask it in sobriety. The very term "gonorrhea" seems to generate a consensus on the part of the citizenry that it is an evil devoutly to be conquered. In point of fact gonorrhea in the antibiotic era has become more of an infection than a disease; that is, the presence of serious tissue damage is infrequently noted. In gay men, for example, complications due to gonorrhea are rare. In heterosexuals the vast majority of men and most women sustain minimal disability. Most of the significant morbidity from gonorrhea is expressed in a painful, debilitating development that afflicts between

10 and 15 percent of infected women: pelvic inflammatory disease (GPID). In this complication and its attendant economic and human wastage lie society's justification for channeling medical resources into gonorrhea control.¹ The disappearance of PID from the disease's clinical spectrum would serve to relegate gonorrhea to a minor place in our health priorities.

GPID Control In Colorado

Ultimate gonorrhea prevention rests with the development of safe immunologic measures. In the absence of vaccines our mandate ought to be to focus control energies on epidemiologic conditions that permit the occurrence of complications like GPID. The progression from uncomplicated cervical to upper genital tract infection in susceptible women requires several weeks to several months. Why, given today's efficacious screening, diagnostic and therapeutic tools, are infected women not detected early enough to prevent the development of complications? Reason suggests four possibilities: a) a sexual partner informed the susceptible of his diagnosis and she ignored it, b) she was informed, presented to a medical provider, and infection was not detected, c) the infected partner could not locate her, or d) the infected partner was unaware of infection (asymptomatic). A study recently conducted in Colorado reveals that the most frequently epidemiologic reason is the latter: 60 percent of the infected partners of GPID women are asymptomatic or minimally symptomatic.² This observation suggests that reducing the prevalence of asymptomatic men will reduce GPID incidence. Em-

pirically, this appears to be holding true; active search for asymptomatic men in Colorado Springs has been associated with a 22 percent reduction in gonorrhea incidence³ and a 35 percent reduction in GPID incidence.^{2,4}

Asymptomatic men can be detected economically by targeted contact tracing and screening. In Colorado Springs, successful detection was occasioned by concentrating contact tracing efforts on fewer than 30 percent of infected women, who represented about 10 percent of *all* reported gonorrhea cases.² High yields obtained in screening high risk men have recently been reported elsewhere: 5.2 percent of 737 consecutive men admitted to Cook County Jail in Chicago were positive for gonorrhea when routine urethral cultures were collected. "Not a single one of these patients had complained of dysuria or urethral discharge in spite of direct questioning."⁵

A similar trial in selected Colorado jails may prove a relatively economical GPID control mechanism. Legal authority for such a procedure already exists.⁶ Certain populations of U.S. servicemen in Colorado are known to have high rates of asymptomatic gonorrhea; screening in these virtually captive audiences may be as productive. Reluctance of potential screenees to submit to intraurethral testing should present no barrier: a non-invasive diagnostic technique, using uncen- trifuged first voided urine, is known to be as effective as the standard (Thayer-Martin) culture method.⁷

Gonorrhea Transmission: Slow or Fast?

The mood of pessimism referred

to in our introductory remarks is grafted onto a pre-existing pessimism: doubt on the part of most health providers about the efficacy of control measures applied to gonorrhea. This pessimism is based on clinical observations: gonorrhea is thought to have a short, highly infectious incubation period, and the infection is essentially asymptomatic in women. These features are deemed to foster such a high spread rate that rapid transmission outruns the best intentioned health interventions.

Meticulous contact tracing, however, suggests that much endemicity is contributed by the asymptomatic man and that gonorrhea transmission occurs much more slowly than heretofore thought;² therefore, many opportunities to interrupt transmission exist within a manageable time frame. This is true not only of GPID epidemiologic efforts but of penicillinase-producing *Neisseria Gonorrhoeae* (PPNG) control initiatives as well. In fact, an examination of PPNG incidence is evidence of the relatively slow progress of gonorrhea transmission. The 1,372 cases reported in the USA from the initial discovery in March, 1976, through August, 1980⁸ can be used as a marker in the universe of gonorrhea transmission. (During the same interval, approximately four and a half million cases of gonorrhea were reported nationally.) This curtailed PPNG burden is not simply an artifact of the superior contact tracing effort surrounding its epidemiology, since about 20 percent of assiduously pursued PPNG contacts are lost to follow-up;⁹ were gonorrhea to spread as rapidly as believed the infected members of this group should have contributed far more than the observed incidence.

Core Groups and Control Prospects

Yorke and colleagues have recently proposed a model of gonorrhea dynamics¹⁰ in which numerically small populations of infected patients are posited to be responsible for most gonorrhea transmission and endemicity. In this stochastic model a small percentage of gonorrhea patients, characterized by prevalence rates of 20 percent or higher, form "core groups" whose socio-sexual

and health-seeking behaviors perpetuate transmission. Empirical evidence for this hypothesis and techniques for the identification of core group members have been attempted in Colorado; findings suggest that focused efforts on relatively small numbers of patients have a disproportionate impact on incidence.^{2,11}

Gonorrhea incidence in Colorado has stabilized at annual levels of 11,500 cases since 1975.³ About 60 percent are men, 350-400 are GPID cases and fewer than half a dozen are PPNG cases. (Reported incidence closely corresponds to actual incidence. A Denver study concluded that correcting for underreporting by the private sector "would serve to increase overall morbidity by 10%."¹² The prevalence of asymptomatic carriage in heterosexual men is estimated to be in the 12-20 percent range. Overall, fewer than 25 percent of all cases may be crucial to the endemicity of gonorrhea.¹¹ It is to these patients that intensive contact tracing and screening services ought to be offered, and to others more selectively.

Screening of high risk women in a variety of clinical settings should continue, because women so detected have been shown to have a high proportion of asymptomatic men in their sexual environment.¹³ Additionally, trials directed at screening high risk men for asymptomatic carriage should be instituted as previously suggested.

Summary

It is relevant to note, as our references attest, that much of what has been learned in gonorrhea epidemiology is of very recent vintage. What emerges from the data is that a thoughtfully targeted approach probably offers the best chance to reduce disease incidence and its complications at a cost tailored to the medical significance of the disease in today's society. If the coming crunch in public funding materializes it will force us to seek frugal solutions. It is clear we cannot offer case management services to all reported cases, even if common sense and legislative mandate¹³ direct us to do so; contact tracing is labor intensive and, thus, expensive.

Investigation in Colorado corroborating the epidemiologic impor-

tance of core group members and asymptomatic men suggest that economical contact tracing and screening opportunities are available.

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12. Rothenberg R, Bross DC, Vernon TM: Reporting of gonorrhea by private physicians: a behavioral study. *Am J Public Health* 70:983-986, 1980.
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CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

December

3 Neuropsychiatric Grand Rounds; 1-3 p.m. APA approved course for Category I credit developed by Colorado State Hospital, Pueblo. Contact: James H. Scully, M.D., 1600 West 24th Street, Pueblo. (303) 543-1170. (Note: Subsequent Grand Rounds will be held January 7, 1982, February 4, 1982, March 4, 1982, April 1, 1982 and May 6, 1982).

3 Practical Therapeutics for Physicians: 1981 -Sheraton Denver Tech Center, Denver, CO. 7 credit hours of Category I AMA-approved. Contact: Beth H. Pillar, Administrative Director of Professional Education, Rocky Mountain Drug Consultation Center, West 8th & Cherokee, Denver, CO 80204 (303) 893-DRUG.

3-5 The Sports Physical Therapy Section of the American Physical Therapy Association in association with the Medical College of Virginia School of Physical Therapy will present the 2nd Annual Combined Physician-Therapist Conference on "The Evaluation and Current Treatment of Athletic Injuries: The Lower Extremity Kinetic Chain" at the Hyatt Regency O'Hare, Chicago, Illinois. Credit: 17 hours AMA Category 1. Contact: Ms. Kathy Johnson, Continuing Medical Education, Box 48, MCV Station, Richmond, Virginia 23298.

4-11 Behavioral Medicine & Primary Care in the 80s - Ilikai Hotel, Honolulu, Hawaii. Sponsored by: Professional Institutes, University of South Carolina School of Medicine. Credits: Approved for 16 hours AMA Category I credit of the Physicians Recognition Award. Approved for 16 prescribed hours by the American Academy of Family Physicians. Contact: Jeri McClain, Administrative Assistant, USC School of Medicine, Office for Academic Affairs, Columbia, South Carolina 29208. Telephone: (803) 777-7470.

9 Regional Computerized Tomography/Neuroradiology/Ultrasound Conference, Department of Radiology, University Hospital, Denver, Colorado 5:30 pm to 9pm, Room #2242. RSVP one week in advance. Contact: Suzanne Warner (303) 394-7774. (3 hours AMA Category I credit) This meeting is sponsored by the Department of Radiology, University Hospital & by the office of Postgraduate Education of the University of Colorado School of Medicine.

10-12 The Management of Patients with Burn Injuries—Brown Palace Hotel. Contact John A. Boswick, Jr., M.D., 4200 E. 9th Avenue, Box C-309, Denver, Colorado 80262. Telephone (303) 394-8718. (18 hours AMA Category I credit.

11-13 Cardiology for the Practicing Physician - Woodlake Inn, Sacramento, California. Tuition: \$155.00 - Credits: 18 hours in Category I. Accreditation from the American Academy of Family Physicians is pending. CONTACT: Office of Continuing Medical Education, School of Medicine, University of California, Davis, CA 95616. (916) 752-0238 Ardi Naiswonger, Publications Representative

20-25 Current Concepts in Pain Management & Current Concepts in Office Management (and the New Tax Law) - Steamboat Springs, Colorado. Structured so that spouses can attend and deduct expenses. Fee: \$250 plus \$150 per spouse. Contact: Current Concept Seminars, 9400 South Dadeland Blvd., Suite 300, Miami, FL, 33156. Tel: (305) 666-0401.

January

"Clinical Cytopathology for Pathologists -Postgraduate Course"—The 23rd Postgraduate Institute for Pathologists in Clinical Cytopathology is to be given at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, Baltimore, Maryland, March 22, 1982 -April 2, 1982. **Please Note: While the course is not until March, 1982, the deadline for applications is shortly after the first of January, 1982, (before 1/27/82).** Contact: John K. Frost, M. D., 610 Pathology Building, The Johns Hopkins Hospital, Baltimore, Maryland 21205.

3-8 Ninth Annual Symposium on Clinical Echocardiography: Clinical Applications & New Developments in Cardiac Imaging at Snowbird Ski Resort - Snowbird Conference Center, Snowbird Ski Resort, Snowbird, Utah. Contact: American College of Cardiology - Ms. Mary Anne McInerney, Director Extramural Programs Department, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

9-16 Current Clinical & Legal Issues: The Mark, Vail, Colorado. Contact: Beth Israel Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone (303) 629-5333; toll-free outside Colorado (800) 525-5810.

10-16 8th Annual Rocky Mountain Conference on Emergency Medicine and Nursing - Keystone Lodge, Keystone, Colorado. Sponsored by the Colorado Chapters of the

American College of Emergency Physicians & the Emergency Department Nurses Association. ACEP and EDNA contact-hour credits are being applied for. Contact: Dee Nylund, Paramedic Services, Swedish Medical Center, 501 East Hampden Ave., Englewood, CO, 80110. Tel: (303) 789-6319.

11-15 **13th Annual Cardiovascular Conference at Snowmass:** Snowmass Resort, Snowmass, Colorado. Contact: Registration Secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014. Telephone: (301) 897-5400.

11-15 **Practical Neurology for the Internist & Family Physician, Postgraduate Course** - The Given Institute, Aspen, CO. 24 hours CME Category 1 Credit. Fee: \$300.00. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, CO 80262. Phone (303) 394-5241.

13-16 **Supercourse VII - A Clinical Course on Critical Pulmonary Care:** Fairmont Hotel, New Orleans, Louisiana. Accredited by the AMA in Category I for the Physicians Recognition Award. Sponsored by the American Lung Association of Louisiana and the American Thoracic Society of Louisiana. Contact: Course Coordinator, American Lung Association of Louisiana, 333 St. Charles Avenue, Suite 500, New Orleans, La. 70130. Telephone: (504) 523-5864.

14-16 **Geriatrics - 1982** - Broadmoor Hotel, Colorado Springs, Colorado. Sponsored by the American College of Physicians and the American Society of Internal Medicine in association with the Colorado Society of Internal Medicine. Contact: Vi Brown, Colorado Medical Society, 1601 East 19th Ave., Denver, CO, 80218. Tel: (303) 861-1221.

16-20 **Eleventh Midwinter Seminar in Ophthalmology** - The Lodge At Vail, Vail, Colorado. 14 hours of Category 1 credit. Fee: COS members, \$50 advance or \$75 on-site. Contact: Vi Brown, Colorado Medical Society, 1601 East 19th Ave., Denver, CO, 80218. Tel: (303) 861-1221.

17-22 **Keystone Summit on Allergy, Immunology and Pulmonology:** Keystone, Colorado. 21 hours of AMA Category I credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital/National Asthma Center, 3800 E. Colfax Avenue, Denver, Colorado 80206. Telephone: (303) 388-4461.

17-22 **Horizons in Surgery, Postgraduate Course** - The Inn at West Vail, Vail, CO. 16 CME Category I credit hours. Fee: \$360.00. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. Phone (303) 394-5241.

18-21 **Chest Radiology - 1981 & 1982**—San Diego, California. Contact: Mary J. Ryals, Suite 101, 10855 Sorrento Valley Road, San Diego, California 92121. Tele: (714) 452-4722.

18-22 **Radiology for the Non-radiologist** -Innisbrook, Florida. 25 hours Category I credit. Contact: Edward A. Eikman, MD, Associate Prof. of Medicine, University of South Florida (Veterans Administration Hospital), 13000 North 30th St., Tampa, Florida 33612. Phone (813) 974-2032.

20-22 **17th Annual Institute of Occupational Medicine** - Broadmoor Hotel, Colorado Springs, Colorado. Sponsored by the Rocky Mountain Academy of Occupational Medicine & the American Occupational Medical Association. Continuing education credits for physicians & nurses will be announced. Contact: Richard L. Masters, MD, Secretary, RMAOM, P.O. Box 39051, Denver, CO, 80239; Tel: (303) 371-0425.

21-23 **"Topics In In-Patient Psychiatry"**—held at The Mark, Vail, Colorado. Room deposits must be made by September 20, 1981. Contact: Joanne H. Ritvo, M. D., Program Chairman, Colorado Psychiatric Society, 1555 East Lake Place, Littleton, Colorado 80121.

24-29 **Eighth Annual Midwinter Program in Continuing Education for Psychiatrists**—Hyatt Lake Tahoe, Incline Village, Nevada. Tuition: \$245.00. Credit: 24 hours in Category I. Contact: Ardi Neiswonger, Office of Continuing Medical Education, School of Medicine, University of California, Davis; Davis, CA 95616. Phone (916) 756-8162.

27 **Health In the Occupational Environment**—Julesberg, Colorado. Number of Colorado Medical Society Category I hours & AAFP prescribed credit: two. Contact: Martin J. Rubinowitz, M. D., The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

27-29 **Sixteenth Annual Vail Midwinter Cancer Seminar: "Diagnostic & Therapeutic Applications of Monoclonal Antibodies/Thyroid Cancer: Present Status."**—The Crest Resort Hotel, Vail, CO. Registration deadline: January 1, 1982. Contact: Midge Cullis, American Cancer Society, Colorado Division, Inc., 1809 E. 18th Ave., Denver, CO 80218. Phone (303) 321-2464.

27-29 **"Echocardiography: An Introduction Course for the Practicing Physician"**—Beverly Hilton Hotel, Beverly Hills, California. Contact: Ms. Mary Anne McInerney, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

30-31 **Medical Applications of Dance, Yoga, and T'ai Chi** - Houston, Texas. Michael E. DeBaKey Center, Baylor College of Medicine, Texas Medical Center, Houston, TX 77030. Duration: 1½ days. Contact: Office of Continuing Medical Education, Baylor College of Medicine (Program Coordinator, Lynn K. Tiras), Texas Medical Center, Houston, TX 77030. Phone (713) 790-4941.

Jan 31-Feb 5 **The Rocky Mountain Pediatric Radiology Seminar** - Vail, CO. Contact: Director

of Professional Education, Rocky Mountain Poison Center, West 8th Ave. & Cherokee St., Denver, CO 80204. Phone (303) 893-7774. 20 Category I AMA credits.

February

6-7 Los Angeles OB-GYN Forum - Beverly Hilton Hotel, Beverly Hills, CA. Accreditation: CMA - 10 hrs. Category I; ACOG - 9 Cognates; AAFP - 10 elective hrs; Nurses - 10 contact hours. Contact: Director of Medical Education, L.A. OB-GYN Society, 5820 Wilshire Blvd., #500, Los Angeles, CA 90036. Phone (213) 937-5514.

6-13 Emergency Medicine/Critical Care at Marriott's Mark Resort, Vail, Colorado. (ACEP credit) 22 credit hours. Urology at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone: (303) 629-5333. Toll-free (800) 525-5810.

7-12 Fifth Annual Postgraduate Course New Approaches to Clinical Problems in Internal Medicine—Snowmass Village, Snowmass, Colorado. Presented by the Department of Medicine, University of Colorado School of Medicine. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone (303) 394-5241.

8-12 The Denver Postgraduate Institute in Emergency Medicine: Pediatrics, OB-GYN & Surgical Subspecialties. Contact: Janice Alexander, Denver Postgraduate Institute in Emergency Medicine, Emergency Medical Services, Denver General Hospital, West 8th & Cherokee, Denver, Colorado 80204. Telephone: (303) 893-7034

8-12 35th Annual Meeting of the Northwestern Medical Association - Scientific/Ski Meeting. Place: Sun Valley, Idaho. Credit: 10 CME Category I. Contact: Norman Christensen, M. D., Secretary, 2456 Buhne Street, Eureka, California 95501.

10-13 21st Annual John R. Durrance Mid-winter Chest Conference - Aspen, Colorado. 10 hours of AMA category 1 credit. Contact: Shirley Lindquist, American Lung Association, P.O. Box 921, Loveland, CO, 80539. Tel: (303) 667-5198.

11-13 "Perspectives on New Diagnostic & Therapeutic Techniques in Clinical Cardiology: Exercise Testing Post Myocardial Infarction, Radionuclide Cardiac Imaging, 2-D and 3-D Echocardiography, Coronary Artery Spasm, Calcium Channel Blockers, Coronary Angioplasty, Thrombolytic Therapy, Coronary Surgery" - Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista, Florida. Contact: Mary Anne McNerny, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20041.

13-20 OB/GYN at Marriott's Mark Resort, Vail, Colorado (ACOG credit); **Psychiatry** at Lion Square Lodge, Vail; **Geriatric**

Medicine at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. (303) 629-5333. Toll-free (800) 525-5810

14-19 Eighth Annual Winter Skin Seminar—The Given Institute of Pathobiology, Aspen, Colorado. Contact: The Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone: (303) 394-5241

14-19 Current Concepts in Pain Management & Current Concepts in Office Management (and the New Tax Law) - Steamboat Springs, Colorado. Fee: \$250.00 plus \$150.00 per spouse. Contact: Current Concept Seminars, 9400 S. Dadeland Blvd., Suite 300, Miami, FL, 33156. Tel: (305) 666-0401

18-20 "Nuclear Medicine For Physicians and Technologists"—San Diego, California. Contact: San Diego Radiology Research & Education Foundation, P. O. Box 2305, LaJolla, CA. 92038. Telephone (714) 453-7500, ext. 3711

20-27 Pathology - Kiandra Lodge, Vail, Colorado; **Radiology** - Aspen Institute for Humanistic Studies, Aspen, Colorado. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO, 80211. Tel: (303) 629-5333 or (800) 525-5810.

22-27 28th Annual Family Practice Review - Postgraduate Course—40 hours CME Category I credit. Fee: \$315.00. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO. 80262. Phone (303) 394-5241.

23-27 Bedside Approach to Cardiac Diagnosis - Keystone, Colorado. Sponsored by Rose Medical Center. Category I credit & AAFP prescribed credit offered. Fees: \$365.00. Information: Dorothy Bailey, Office of Education, Rose Medical Center, 4567 E. 9th Ave., Denver, CO 80220. Phone (303) 320-2102.

26-28 Extra Extracapsular Cataract & Anterior & Posterior Intraocular Lens Implant Course. Place: The Waiohai Hotel, Kauai, Hawaii. Course Director: David S. Pfoff, MD. Fee: \$700.00 for didactic & lab; \$400.00 for didactic only. Contact: Colleen Requist, c/o Dr. Pfoff's office, 950 E. Harvard Ave., Suite 350, Denver, CO. 80210. Phone (303) 777-5457.

26-28 Tenth Annual Taos Lung Disease Symposium - Kachina Lodge, Taos, NM. Contact: New Mexico Chapter of the American Thoracic Society, 216 Truman NE, Albuquerque, NM. 87108. Phone (505) 265-0732.

Feb 27-Mar 7 Cancer Treatment -at Kiandra Lodge, Vail, CO.—Sports Medicine at Lion Square Lodge, Vail, CO. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO 80211. Phone (303) 629-5333; (800) 525-5810.

Feb 28-Mar 5 Infectious Diseases and

Rheumatology Course - The Givn Institute, Aspen, CO. Category I and AAFP Prescribed credit. Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Denver, CO 80262. Phone (303) 394-5241 or 5195.

March

2-5 35th Annual Symposium on Fundamental Cancer Research "Perspectives on Genes & the Molecular Biology of Cancer."—Shamrock Hilton Hotel, Houston, TX. Information: Stephen C. Stuyck, Director, Public Information & Education, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Ave., Houston, TX 77030. Phone (713) 792-3030.

4-6 Third Annual Radiologic Technologists Course - San Diego, CA. Contact: San Diego Radiology Research & Education Foundation, P.O. Box 2305, LaJolla, CA 92038. Phone: (714) 453-7500, ext. 3711.

6-13 Family Practice at Marriott's Mark Resort, Vail, CO.—General Surgery at Lion Square Lodge, Vail—General Dentistry at Kiandra Lodge, Vail (AGD & ADA credit). Contact: Beth Israel, Conference Program, Box 11366, Denver, CO 80211. Phone (303) 629,5333, (800) 525-5810.

8-10 Gastroenterology for Clinicians - Learning in the Sun—Scottsdale, Arizona. AMA Category I and AAFP credit - 16½ hours. Contact: Mrs. David C. H. Sun, David C. H. Sun Memorial Institute, 4129 E. Sandy Mt. Road, Scottsdale, ARIZ. 85253. Phone: (602) 948-1064.

8-12 High Risk Infant Care - Postgraduate Course - Denver, Colorado. 34 Category I credit hours with 6 additional hours credit available for workshops. Fee: \$300.00 plus \$75.00 for workshops. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. Phone (303) 394-5241.

8-12 Poisoning: a Symposium - Denver, Colorado. Sponsored by the Rocky Mountain Poison Center, Denver, Colorado. 32.5 Category 1 AMA credits. Tuition: General Session -\$305 for physicians if postmarked by 1/15/82, \$320 if later; \$210 for nurses & pharmacists if postmarked by 1/15/82, \$225 if later; Special Seminar \$75 (Current Trends in Drug Therapy); Special Seminar \$40 (Poison Center Management of Common Poisonings); Toxicokinetics Workshop \$25. Contact: Director of Professional Education, Rocky Mountain Poison Center, West 8th & Cherokee St., Denver, CO, 80204. Tel: (303) 893-7774.

8-12 Sports Medicine, Postgraduate Course in: - Maui, Hawaii. Sponsored by the Northwestern Center for Sports Medicine. The course has been planned to coincide with the Maui Marathon and will carry 25 hours of Category 1

CME credit. Contact: Bates Noble, MD, Couse Director, Northwestern University Center for Sports Medicine, 303 East Chicago Ave., Chicago, IL, 60611.

13-20 Internal Medicine - Lion Square Lodge, Vail: **Pediatrics** - Marriott's Mark Resort, Vail: **Clinical Brain** -Kiandra Lodge, Vail Colorado. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO, 80211. Tel: (303) 629-5333 or (800) 525-5810.

14-19 Third Annual Mammoth Mountain Emergency Ski Conference - Mammoth Lakes, Professor: John A. Herring, MD, Dallas, Texas. Credit: AMA Category 1, AAFP approval applied for. Contact: Robert E. Eilert, MD, 1056 East 19th Ave., Denver, CO, 80218. Tel: (303) 861-6600.

21-28 St. Moritz 1982: Advances in Diagnostic Imaging - Palace Hotel, St. Moritz, Switzerland. Contact: Edward A. Eikman, MD, Associate Professor of Medicine, University of South Florida, College of Medicine, Veterans Administration Hospital, 13000 North 30th St., Tampa, FL 33612. Tele: (813) 974-2032.

23-26 Gastrointestinal Radiology with Emphasis on Imaging & Invasive Techniques - San Diego, California. Contact: San Diego Radiology Research and Education Foundation, P.O. Box 2305, La Jolla, CA 92038. Tele: (714) 453-7500, ext 3711.

April

16 Children's Orthopedic Day - The Children's Hospital, Denver, Colorado. Visiting Professor: John A. Herring, MD, Dallas, Texas. Credit: AMA Category 1, AAFP approval applied for. Contact: Robert E Eilert, MD, 1056 East 19th Ave., Denver, CO 80218. Tele: (303) 861-6600.

Apr 25-May 3 4th Annual Current Concepts in Musculoskeletal Radiology and Orthopedics -Athens, Greece. Sponsored by the Mallinckrodt Institute of Radiology and the Department of Clinical Therapeutics of the Athens University Medical School. Contact: Luis A. Gilula, MD, Mallinckrodt Institute of Radiology, 510 South Kingshighway Blvd., St. Louis, MO, 63110.

28 Fingertip Repair - Julesberg, Colorado. 2 hours CMS Category 1 and AAFP prescribed credit. Contact: Martin J. Rubinowitz, MD, The Denver Clinic, 701 East Colfax Ave., Denver, CO, 80203.

May

16-20 Fifth International Symposium on the Prevention & Detection of Cancer - Sao Paulo, Brazil. CME Credit hours are arranged for U.S. participants. Contact: Medical Congress Coordinators Dept., 1212 Avenue of the Americas, New York, NY, 10036. Phone: (212) 840-0110.

Michael Frank Borysow, MD, of Denver, died in an auto-pedestrian accident on October 11, 1981. Dr. Borysow was struck and run over by car in a parking lot near Denver's Mile High Stadium following a Denver Bronco football game.

Borysow, 42, was born in Nowa Grudek, Poland, on March 9, 1939. He graduated from the University of Illinois and interned at St. Joseph Hospital in South Bend, Indiana. He served in the United States Army and had been practicing in Denver for the past 11 years. Dr. Borysow was a staff physician at Presbyterian, St. Lukes and Veterans Administration hospitals, and also served as medical director of Raleigh Hills Hospital and Julia Temple Nursing Home in Englewood. He was a member of the Denver and Colorado Medical Societies and the AMA.

Dr. Borysow lived with his wife, Michelle Anne, and three children at 4301 So. Holly Street in Englewood.

Velma G. Crawford, MD, died on October 25, 1981, following an illness. Dr. Crawford, 75 years of age, was born January 21, 1906, in La Moure, North Dakota. Following two years teaching in a country school in her home state, she went to Loma Linda University in California and became a registered nurse. She then received her medical degree from Loma Linda.

After coming to Denver in 1945, interning in Boulder and at Porter Memorial Hospital, Dr. Crawford became a general practitioner in Englewood. She was on the staff at Porter and Swedish Medical Center. She was a member of the Arapahoe

Medical Society and a life emeritus member of Colorado Medical Society. Dr. Crawford retired from active practice in 1973 because of ill health. She is survived by a sister, Verna Lancaster, of Las Vegas, Nevada.

Cecil S. Mollohan, MD, of 3400 South Clermont Street in Denver, died on October 8, 1981, a short time after being struck by a car in southeast Denver.

Dr. Mollohan, 76, was born October 4, 1905, in Servia, W.Va. After attending schools in Colorado he graduated from Sterling High School and the University of Colorado's medical class in June, 1928. He was an intern at Gorgas Hospital in the Panama Canal Zone. While there he became familiar with tropical diseases and also operated a leper colony for one year. Dr. Mollohan returned to Telluride, Colorado, where he established a private practice before enlisting in the Army in 1932. He served with the Army in China, Europe and throughout the United States.

As an Army officer in the 1950s, Mollohan was assigned to a special United Nations task force responsible for trying to restore peace in Indonesia after that country had been at odds with the Netherlands. It was the suggestion of Dr. Mollohan which brought both the Sukarno government and officials of the Netherlands together in the Harbor of Batavia on board the U. S. Naval Transport Renville. The meeting led to agreement between the two parties on how to rebuild the country. Because of his efforts in bringing the parties together, a long-lasting friendship developed between

Mollohan and President Sukarno. Dr. Mollohan went on to serve for five years on the staff of the Supreme Command of Allied Powers under General Douglas MacArthur, throughout the Korean conflict.

Dr. Mollohan retired from the Army with the rank of colonel, and joined the Colorado Health Department in October, 1957, serving as chief epidemiologist until his retirement October 15, 1972. He was a member of the Denver and Colorado Medical Societies. Dr. Mollohan's wife of 45 years, Emily, died in 1975. Dr. Mollohan is survived by two daughters and four grandchildren.

Myron Wilkoff, MD of Denver, died on October 10, 1981, after a long illness. Dr. Wilkoff was 72. He was born January 9, 1909, in Youngstown, Ohio, came to Denver in 1927, and graduated from the University of Colorado School of Medicine in 1936. He returned to the east to serve his medical residencies at the University of Pennsylvania and the Charleston, W.Va., General Hospital, before coming back to Denver to settle.

During his 45 years of medical practice in the Denver community, Dr. Wilkoff served as chief of staff at Lutheran Medical Center, and was the founder and first president of Rodef Shalom Synagogue. He was a member of the Denver and Colorado Medical Societies. He and his wife, Frieda, had celebrated their 50th wedding anniversary in September, 1981. He is survived by his wife, a daughter, a son, two brothers and four grandchildren.

PROFESSIONAL OPPORTUNITIES

DIRECTOR OF MEDICAL EDUCATION: needed at Penrose Hospital, Colorado Springs. Physician wanted to direct a comprehensive and accredited program of continuing medical education. Prior CME experience not necessary to apply. Three years clinical experience required. Contact P.J. O'Rourke, MD Chairman, Search Committee for DME, Penrose Hospitals, P.O. Box 7021, 2215 N. Cascade Ave., Colorado Springs, CO 80907. (303) 630-5000. 781-29-3b

CALIFORNIA: Director positions available emergency medicine physicians needed for rural California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, Board Certification or at least two years experience required. Excellent benefit package and profit sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610, (415)832-6400. 381-1-TFN

GROW WITH US IN SUNNY ARIZONA: The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Attractive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living appeal to you, send your CV to: Professional Relations, INA Healthplan, Inc., 6115 North 7th Street, Phoenix, AZ 85014. 181-1TFN

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OPHTHALMOLOGIST NEEDED: Delta County in Western Colorado with population of 30,000 needs an ophthalmologist who can do eye surgery and refractions. Office space available next to hospital. An AO operating microscope and kryoprobe is available. CONTACT: R. J. Bennett, M.D., 70 Stafford Lane, Delta, Colorado 81416. (303) 874-4473. 981-4-3b

PEDIATRICIAN: Colorado Springs -Associate desired: Fun, active practice. CONTACT: Peter J. Adasek, M.D., FAAP, 2512 N. Cascade Ave., Colorado Springs, Colorado 80907. CALL: (303) 473-6100 DAYTIME, (303) 687-2621 EVENINGS. 881-25-3B

SHARE MEDICAL SPACE with allergist at one or both locations, 51 W. 84th Ave., Thornton and 3401 S. Oneida Way, Denver. Three full days and personnel available. CONTACT: Dr. Tuft, (303) 753-1076. 1181-6-3b

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CONTACT: Bob Woodward, Adm., St. Vincent General Hospital, Leadville, Colorado 80461 -(303) 486-0230. 1081-16-3b

FAMILY PRACTICE PHYSICIAN wanted to join 1-year old practice in Longmont, Colorado. For further information WRITE: Susan Bunnell, MD, 1309 Frontier Avenue, Longmont, Colorado 80501. 1181-7-3b

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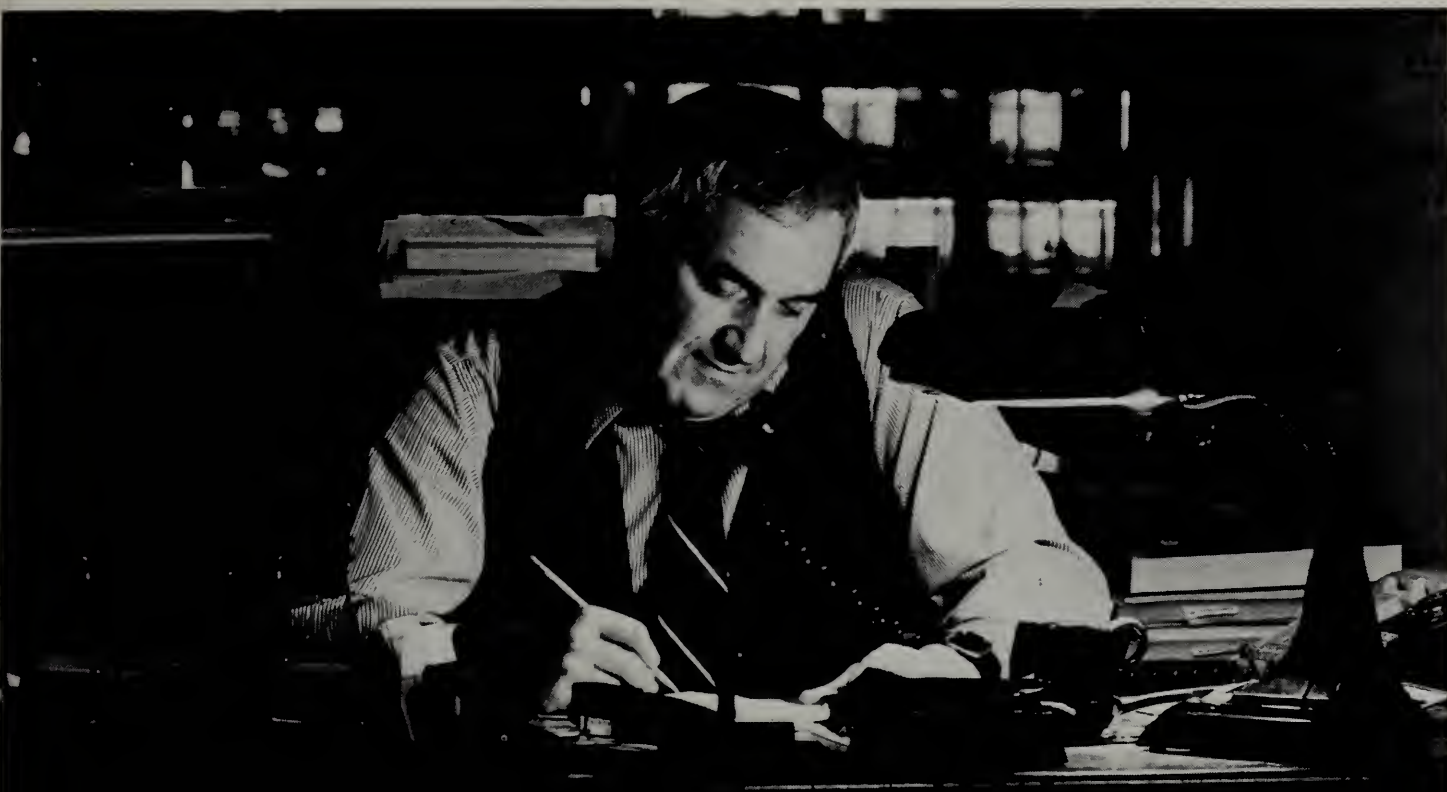
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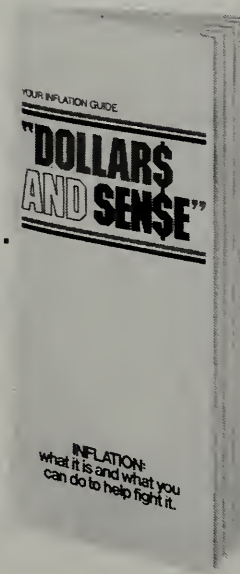
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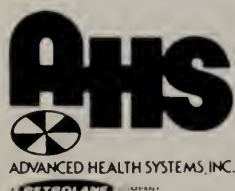
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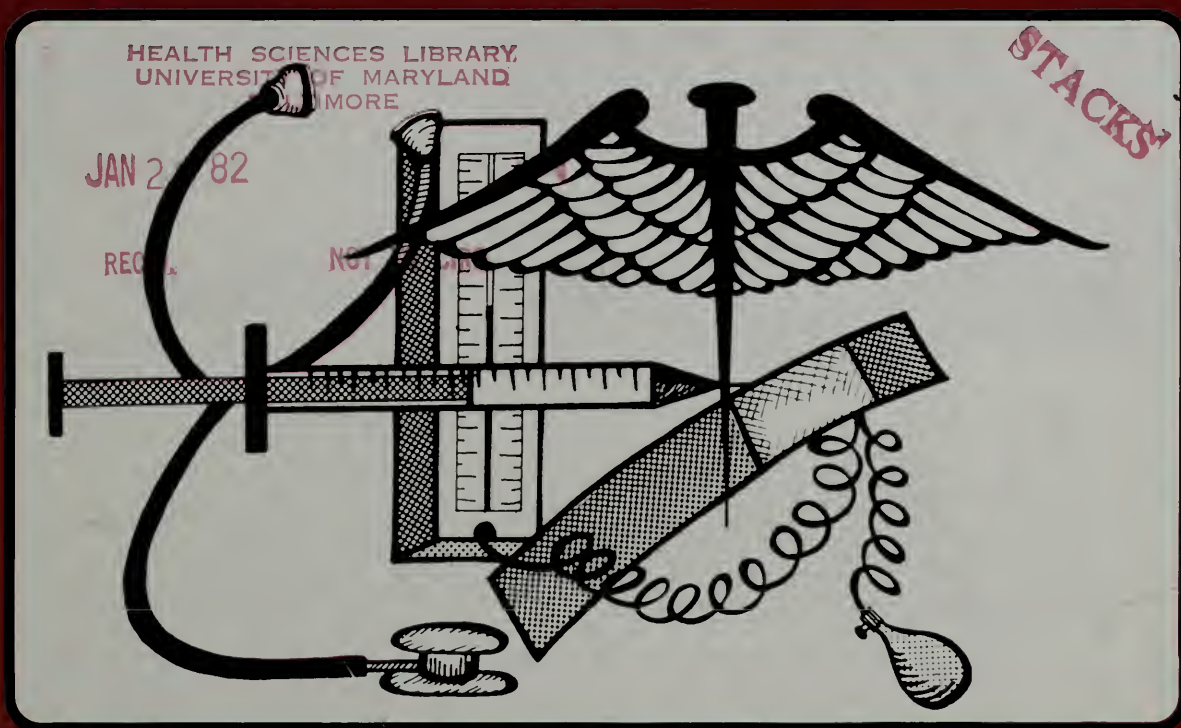
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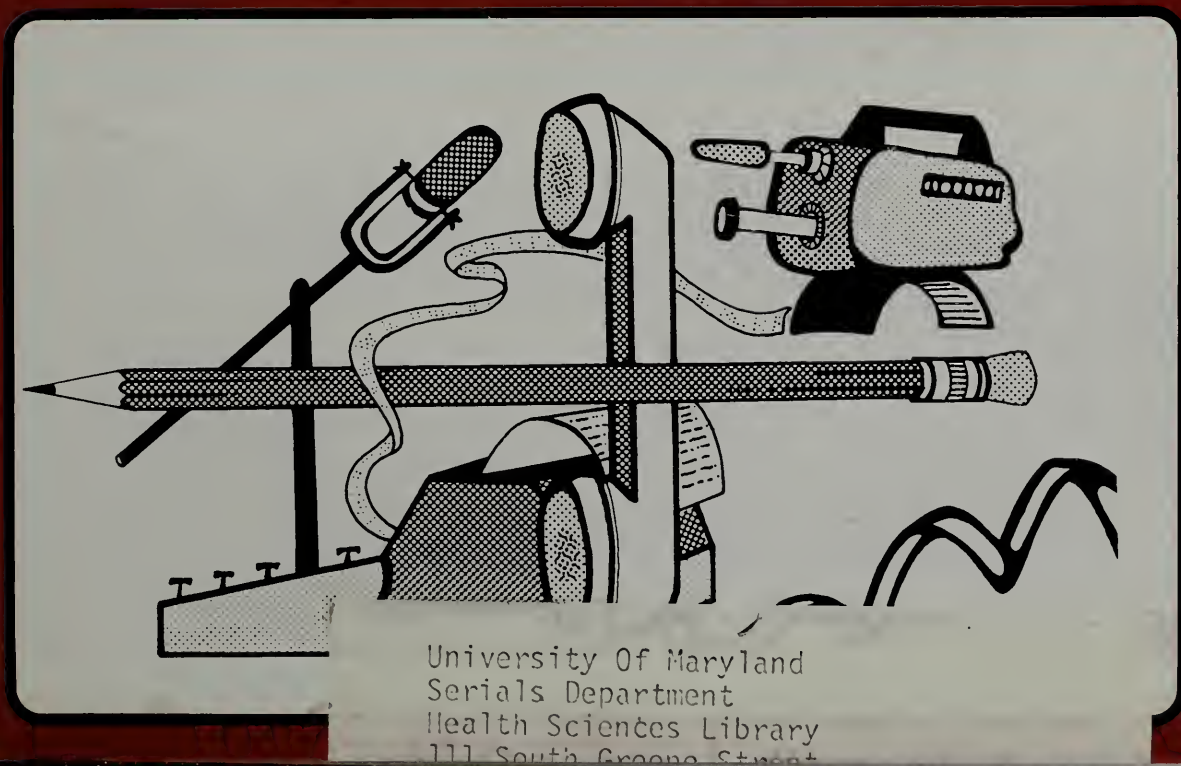
Volume 78, Number 12

PROPERTY & INVESTMENT
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Code of Cooperation: Does the System Work?

First Grievance Hearing Airs Differences Between News Media and Physicians



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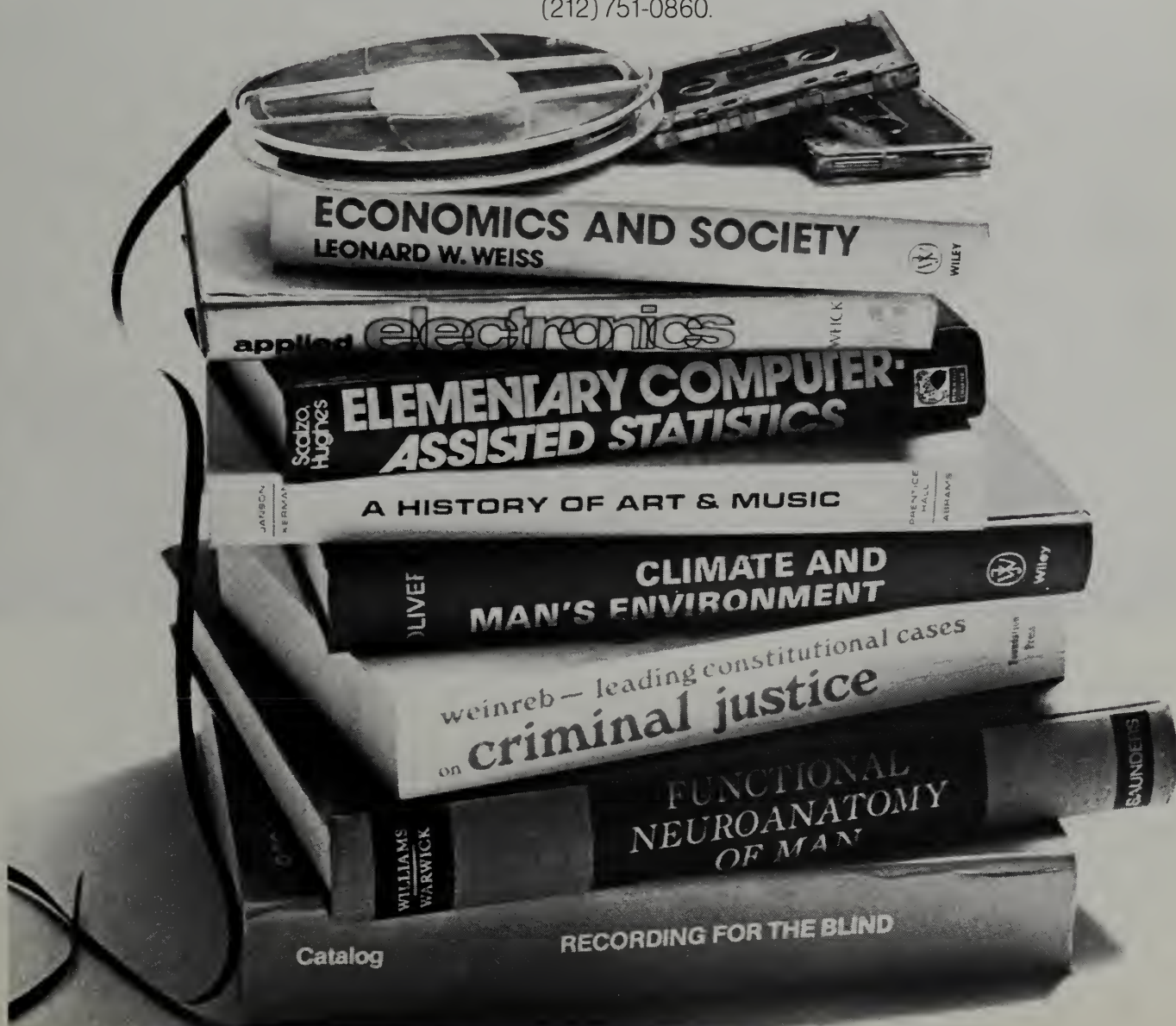
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CMS Buys 10 Acres of Land

1st Two Weeks of Land Offering Generates over \$.5 Million

Property & Investment Offering Attracts Broad Cross-Section of CMS Membership

Property & Investment Offering Update: In less than one month from the date of a special offering, a prospectus of which was mailed every member of CMS, interest is very high in purchase of bonds as an investment opportunity. This offering of an investment, paying 18% on 5-year bonds, in two weeks time generated over \$.5 Million, but there are still approximately 1,900 bonds at \$500 each, available for sale to interested members who are residents of Colorado and over 21 years of age.

Colorado Medical Society, after a full year of planning and negotiations, authorized the CMS Building Committee to purchase the land, located in the southeast sector of metropolitan Denver. The land is located in an area of prime development. Colorado Medical Society needs a permanent home; this investment will assist the society and its membership in accomplishing that goal.

This offering is an opportunity for you to invest monies from your pension funds, from Keogh or IRA ac-

counts, or, acting as a trustee, to invest for your children and heirs.

Closing date of this offering is in January, 1982, but the sale of these bonds has proceeded at a rapid pace during the first half of December, so there is not much time left.

If you have questions about the prospectus or the offering, in general, please contact: **Chris Stein, Executive Director, Department of Finance, Colorado Medical Society, 861-1221.**



Standing in the center of the 10-acre site at South Broadway and Mineral Avenue, looking west-northwest from the approximate center of the CMS property (a panoramic view which actually stretches from Pikes Peak on the south, over downtown Denver and the Platte River Valley, northwest to Long's Peak and the Twin Sisters). The paving, curb and gutters, cul-de-sac access to the property have since been built. Other improvements, such as landscaping, are now being put in place. This acreage allows for an excellent single structure or office complex, located just west of Broadway and south of Mineral Avenue. The CMS property has a total 477' frontage on South Broadway, a primary access from Englewood and Littleton, south to County Line Road and the rapidly-developing Highlands Ranch. The frontage on Mineral Avenue measures 895' and a set-back of 50' on both street sides.

The property purchased by Colorado Medical Society is less than two miles west of the projected center of Denver population in the year 1990.



Cover Story:

October saw the first grievance procedure at work before the Colorado Code of Cooperation Committee. This committee was formed in 1946 and was one of the leaders in developing information guidelines for working press-hospital-physician relations. The hearing marks the first grievance procedure to be carried to a formal resolution in the 35-year history of the committee. All of the testimony given before the Grievance Committee has been included in this issue for the benefit of all participants in this crucial area of public health care and information. Details and conclusions will apply to your own situation, though conditions will differ from area to area.

The decisions of the members of the Grievance Committee are also printed in this issue. It is the hope of the publishers of Colorado Medicine that such information will be of help to all hospital administrators and staff, to physicians and news reporters, for the fulfillment of the public's need (and right) to know, and the rights of the hospital, the patient and the physician to determine the needs of informing the public.

articles

469 Code of Cooperation...Does it Work? Complete hearing testimony before the Grievance Committee of the Colorado Code of Cooperation (See: "Cover Story," top-right, this page), at the Denver Post Publishing Co. takes the University of Colorado Health Sciences Center to task.

Denver Post grievance concerns the question: when does a hospital patient become a "public figure," and how does this change the handling of a news story?

480 Results of Grievance Hearing: The findings of the members of the Grievance Committee are varied, with recommendations of possible changes in the Code of Cooperation.

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features

453 Women's Health Conference - 1982: The Council on Public Health will again sponsor a Conference on the Health Concerns of Women, in conjunction with numerous other agencies and organizations. The 1981 Conference was deemed highly successful and important enough to present this coming year. Announcement of participants, dates and places will be made early in 1982.

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Drug Fraud Not Limited to One Area

Editor:

I would like to advise you of a Prescription Fraud routine that is currently being used in our area.

There is a group of people masquerading as doctors and narcotics detectives in order to obtain dilaudid and other drugs.

First, a party claiming to be a narcotics detective calls a doctor's office while the doctor is out. The party

then requests the nurse's/receptionist's assistance in the investigation. After the fake detective obtains the nurse's cooperation he tells her that she will be contacted shortly by a pharmacist. The party will then tell the nurse to OK a prescription for dilauidids for a subject. The party then tells the nurse that he and his men will catch the suspect as he leaves the pharmacy.

After contacting the nurse, the party then calls a pharmacy claiming to be a doctor. The party asks the pharmacist to fill a prescription and then double-check with his nurse.

These parties have used this method to obtain large quantities of dilaudid on several occasions.

I thank you for any time and assistance that you can give me in apprehending these parties.

Sincerely,

Det. G. Barter
Metro Narcotics Unit
Colorado Springs
Police Department
Phone 471-6704

Prescription Fraud Alert

December 1, 1981

To: Physicians and Pharmacists

Your attention is called to the following prescription frauds:

Stolen Order Forms

1. Dr. Walter Robinson, MD, 8350 West 38th Avenue, Wheat Ridge, CO, 421-3425. Forgeries for Percodan have been passed under the patient name Tom Trauber.

2. Dr. Alvin Otsuka, MD, 8585 Huron Street, Denver, CO, 837-0415. Forgeries for Dilaudid 2 mg have been passed under the patient name May Benson. The order forms are from Dr. Otsuka's old office and have the old address of 1929 Egbert Street, Brighton.

3. Dr. Norman Scott, MD, Colorado Permanente (Kaiser), 8383 W. Alameda, Lakewood, CO, 232-1885, ask for Pediatrics. These are standard Colorado Permanente prescription order forms with Dr. Scott's name at the bottom. Forgeries have been passed for Ambenyl Expectorant.

Pharmacists please verify all narcotic and Schedule II drug prescriptions with these physicians.

Drug - Tylenol No. 4

An unknown man is impersonating Dr. David Madison, MD, 5150 East Yale Circle, 757-6408, and phoning in prescriptions for a Howard Roberts for Tylenol No. 4. Suspect is a white male, age 26 to 28, 5'10" tall, medium build with stringy light brown hair, described as having an oval face. Please verify all narcotic and Schedule II drug prescriptions with Dr. Madison.

Charles Johnston
Director Department of
Public Safety
Ron Beckham
Captain
Intelligence Division



Your State Medical Society is currently involved in two major projects which will have a profound impact on the long range future of the CMS and the physicians in this state.

These two projects are 1) the future of the CMS Professional Liability Trust (the CMS sponsored malpractice liability insurance program) and 2) the land acquisition and building program. I would like very much to be able to report to you on the progress of these two vital programs but events are moving so rapidly in both areas that anything I wrote now would be hopelessly out of date by the time you read it. Both programs need your support and I would urge all of you to read the mail you receive from CMS so that you can keep abreast of new developments.

However, I can report to you on the progress we have made toward some of the goals which were set for this year:

In terms of the sign up of physicians in the CMS Professional Liability Trust, we are currently running around 60 percent. We would hope that this figure increases as understanding of the Trust grows. We have every reason to believe that at least 2500 physicians will be Trust members by the end of the year. If you have any questions about the Trust when your malpractice insurance comes up for renewal, please call me, Dr. Mason Howard, or the CMS staff.

As of this writing, it would appear that we have exceeded the magic number and will have 3 delegates

and alternates to the AMA next year. I would like to thank all of you who, for the first time, joined the AMA this year and hope that you will renew your membership next year.

Another of our goals is increased membership in COMPAC. The staff tells me that there has already been a significant increase, both in the number of physicians joining COMPAC and the amount contributed. Once again, I would like to thank all of you who joined COMPAC and suggest that those of you who didn't, reconsider.

One of my firm convictions is that the CMS exists to serve its membership. However, it is difficult to know how well we are accomplishing this unless we hear from physicians around the state. As with any organization, there may be times when you have difficulty getting through the "bureaucracy." If this does happen to any of you, I would suggest that you contact me directly — either by phone or letter. I assure you that I will do whatever I can to expedite the solution of your problem, whatever it might be.

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Rob or Les

On January sixth, the Colorado legislature will kick off its 1982 session — an even-year "short session" during which the only bills that can be considered are either those listed by the governor or those producing revenue for the state. With 1981 being an election year for both the governor and the legislature, one can assume that the governor's list of bills will be as short and as non-controversial as possible.

Proposed issues that will be of interest to physicians are:

- Catastrophic health insurance,
- Expansion of the medicaid program to a group of persons considered "medically needy,"
- A change in the hearing process used by the Board of Medical Examiners,
- Several items in the long budget bill: More dollars for the medically indigent, more Medicaid dollars for physicians, and seven new attorneys to eliminate the legal backlog of the Board of Medical Examiners.

A sentiment seems to be surfacing to tighten the delegatory clause in the medical practice act and better define to whom a medical task may be delegated and how it must be supervised. This move is afloat in other states also, and it seems to be instigated by the pharmaceutical associations. We will be watching carefully for bill titles under which such a concept might be incorporated.

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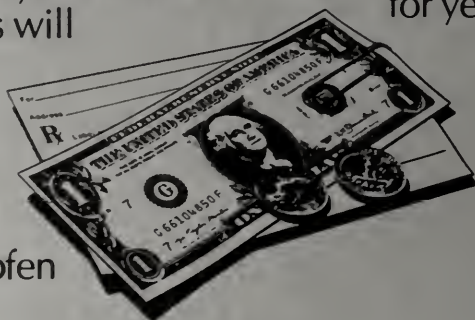
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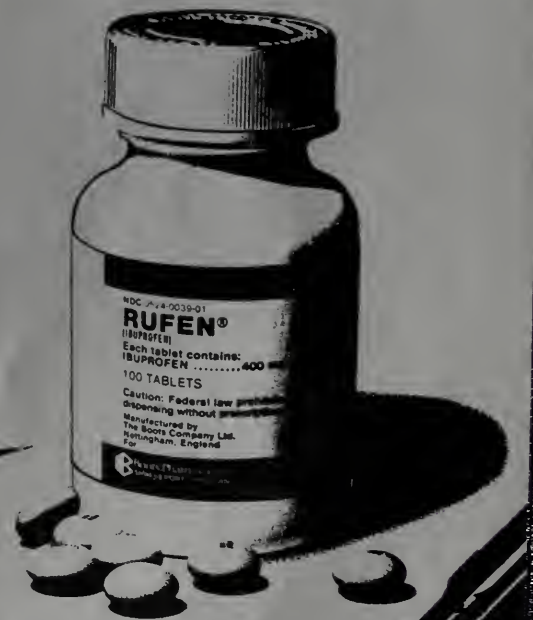
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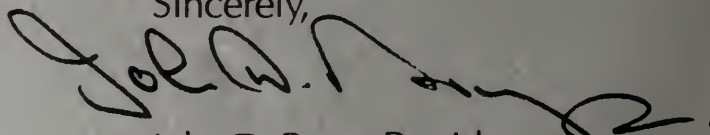
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Sincerely,



John D. Bryer, President
Boots Pharmaceuticals, Inc.

 **Boots Pharmaceuticals, Inc.**
6540 LINE AVENUE, SHREVEPORT, LOUISIANA 71106

Pioneers in medicine for the family

RUFEN®

(ibuprofen/Boots)

(For full prescribing information, see package brochure.)

RUFEN® Tablets

(ibuprofen)

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

January

"Clinical Cytopathology for Pathologists - Postgraduate Course"—The 23rd Postgraduate Institute for Pathologists in Clinical Cytopathology is to be given at the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, Baltimore, Maryland, March 22, 1982 - April 2, 1982. **Please Note: While the course is not until March, 1982, the deadline for applications is shortly after the first of January, 1982, (before 1/27/82).** Contact: John K. Frost, M. D., 610 Pathology Building, The Johns Hopkins Hospital, Baltimore, Maryland 21205.

3-8 Ninth Annual Symposium on Clinical Echocardiography: Clinical Applications & New Developments in Cardiac Imaging at Snowbird Ski Resort - Snowbird Conference Center, Snowbird Ski Resort, Snowbird, Utah. Contact: American College of Cardiology - Ms. Mary Anne McInerney, Director Extramural Programs Department, 9111 Old Georgetown Road, Bethesda, Maryland 20014.

9-16 Current Clinical & Legal Issues: The Mark, Vail, Colorado. Contact: Beth Israel Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone (303) 629-5333; toll-free outside Colorado (800) 525-5810.

10-16 8th Annual Rocky Mountain Conference on Emergency Medicine and Nursing - Keystone Lodge, Keystone, Colorado. Sponsored by the Colorado Chapters of the American College of Emergency Physicians & the Emergency Department Nurses Association. ACEP and EDNA contact-hour credits are being applied for. Contact: Dee Nylund, Paramedic Services, Swedish Medical Center, 501 East Hampden Ave., Englewood, CO, 80110. Tel: (303) 789-6319.

11-15 13th Annual Cardiovascular Conference at Snowmass: Snowmass Resort, Snowmass, Colorado. Contact: Registration Secretary, Extramural Programs Department, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20014. Telephone: (301) 897-5400.

11-15 Practical Neurology for the Internist & Family Physician, Postgraduate Course - The Given Institute, Aspen, CO. 24 hours CME Category 1 Credit. Fee: \$300.00. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, CO 80262. Phone (303) 394-5241.

13-16 Supercourse VII - A Clinical Course on Critical Pulmonary Care: Fairmont Hotel, New Orleans, Louisiana. Accredited by the AMA in Category I for the Physicians Recognition Award. Sponsored by the American Lung Association of Louisiana and the American Thoracic Society of Louisiana. Contact: Course Coordinator, American Lung Association of Louisiana, 333 St. Charles Avenue, Suite 500, New Orleans, La. 70130. Telephone: (504) 523-5864.

14-16 Geriatrics - 1982 - Broadmoor Hotel, Colorado Springs, Colorado. Sponsored by the American College of Physicians and the American Society of Internal Medicine in association with the Colorado Society of Internal Medicine. Contact: Vi Brown, Colorado Medical Society, 1601 East 19th Ave., Denver, CO, 80218. Tel: (303) 861-1221.

16-20 Eleventh Midwinter Seminar in Ophthalmology - The Lodge At Vail, Vail, Colorado. 14 hours of Category 1 credit. Fee: COS members, \$50 advance or \$75 on-site. Contact: Vi Brown, Colorado Medical Society, 1601 East 19th Ave., Denver, CO, 80218. Tel: (303) 861-1221.

17-22 Keystone Summit on Allergy, Immunology and Pulmonology: Keystone, Colorado. 21 hours of AMA Category I credit, AAFP credit pending. Contact: Mary Fletcher, National Jewish Hospital/National Asthma Center, 3800 E. Colfax Avenue, Denver, Colorado 80206. Telephone: (303) 388-4461.

17-22 Horizons in Surgery, Postgraduate Course - The Inn at West Vail, Vail, CO. 16 CME Category I credit hours. Fee: \$360.00. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. Phone (303) 394-5241.

18-21 Chest Radiology - 1981 & 1982—San Diego, California. Contact: Mary J. Ryals, Suite 101, 10855 Sorrento Valley Road, San Diego, California 92121. Tele: (714) 452-4722.

18-22 Radiology for the Non-radiologist -Innisbrook, Florida. 25 hours Category I credit. Contact: Edward A. Eikman, MD, Associate Prof. of Medicine, University of South Florida (Veterans Administration Hospital), 13000 North 30th St., Tampa, Florida 33612. Phone (813) 974-2032.

20-22 17th Annual Institute of Occupational Medicine - Broadmoor Hotel, Colorado Springs, Colorado. Sponsored by the Rocky Mountain Academy of Occupational Medicine & the American Occupational Medical Association. Continuing education credits for physicians & nurses will be announced. Contact: Richard L. Masters, MD, Secretary, RMAOM, P.O. Box 39051, Denver, CO, 80239; Tel: (303) 371-0425.

21-23 "Topics in In-Patient Psychiatry"—held at The Mark, Val, Colorado. Room deposits must be made by September 20, 1981. Contact: Joanne H. Ritvo, M. D., Program Chairman, Colorado Psychiatric Society, 1555 East Lake Place, Littleton, Colorado 80121.

22-23 Fourth Annual Postgraduate Course in Surgery. Red Lion Motor Inn, Sacramento, California. Topics: Gastrointestinal Surgery: Surgical Infections & Trauma: Endocrine, Biliary Tract, and Pancreas. Credit: 15 hours in Category I, AMA & CMA. Tuition: \$125 MD; \$75 Sacramento Surgical Society members. Information: Ardi Neiswonger, Publications Representative, Office of Continuing Medical Education, School of Medicine, University of California at Davis. Telephone (916) 752-0328 Office of CME.

24-29 Eighth Annual Midwinter Program in Continuing Education for Psychiatrists—Hyatt Lake Tahoe, Incline Village, Nevada. Tuition: \$245.00. Credit: 24 hours in Category I. Contact: Ardi Neiswonger, Office of Continuing Medical Education, School of Medicine, University of California, Davis; Davis, CA 95616. Phone (916) 756-8162.

25-27 Nutritional Care of Problem Patients -LaPosada Resort, Scottsdale, Arizona. Credit: 17 hours of Category I credit by AMA; 17 hours of Prescribed credit for AAEP. Contact: Robert B. Gilsdorf, MD, Dept. of Nutritional Research, Good Samaritan Hospital, P.O. Box 2989, 1033 East McDowell Road, Phoenix, Arizona 85062. (602) 257-4383.

27 Health in the Occupational Environment—Julesberg, Colorado. Number of Colorado Medical Society Category I hours & AAEP prescribed credit: two. Contact: Martin J. Rubinowitz, M. D., The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

27-29 Sixteenth Annual Vail Midwinter Cancer Seminar: "Diagnostic & Therapeutic Applications of Monoclonal Antibodies/Thyroid Cancer: Present Status."—The Crest Resort Hotel, Vail, CO. Registration deadline: January 1, 1982. Contact: Midge Cullis, American Cancer Society, Colorado Division, Inc., 1809 E. 18th Ave., Denver, CO 80218. Phone (303) 321-2464.

27-29 "Echocardiography: An Introduction Course for the Practicing Physician"—Beverly Hilton Hotel, Beverly Hills, California. Contact: Ms. Mary Anne McInerney, American College of Cardiology, 9111 Old

Georgetown Road, Bethesda, Maryland 20014.

28-30 Ethical Decisions - 54th Winter Conference - University of Northern Colorado, Greeley. Contact: Winter Conference, College of Education, University of Northern Colorado, Greeley, Colorado 80639.

30-31 Medical Applications of Dance, Yoga, and T'ai Chi - Houston, Texas. Michael E. DeBakey Center, Baylor College of Medicine, Texas Medical Center, Houston, TX 77030. Duration: 1½ days. Contact: Office of Continuing Medical Education, Baylor College of Medicine (Program Coordinator, Lynn K. Tiras), Texas Medical Center, Houston, TX 77030. Phone (713) 790-4941.

Jan 30 - Feb 6 Cardiology Conference - Sheraton at Steamboat Springs, Colorado. Credit: 22 hours of AMA Category 1 and AAFP Prescribed. Contact: Beth Israel Community Health & Education Fund, P.O. Box 11366, Denver, Colorado 80211. Ms. Penny Minkler, Conference Coordinator -(303) 629-5333; (800) 525-5810.

Jan 31-Feb 5 The Rocky Mountain Pediatric Radiology Seminar - Vail, CO. Contact: Director of Professional Education, Rocky Mountain Poison Center, West 8th Ave. & Cherokee St., Denver, CO 80204. Phone (303) 893-7774. 20 Category I AMA credits.

February

6-7 Los Angeles OB-GYN Forum - Beverly Hilton Hotel, Beverly Hills, CA. Accreditation: CMA - 10 hrs. Category I; ACOG - 9 Cognates; AAFP - 10 elective hrs; Nurses - 10 contact hours. Contact: Director of Medical Education, L.A. OB-GYN Society, 5820 Wilshire Blvd., #500, Los Angeles, CA 90036. Phone (213) 937-5514.

6-13 Emergency Medicine/Critical Care at Marriott's Mark Resort, Vail, Colorado. (ACEP credit) 22 credit hours. Urology at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. Telephone: (303) 629-5333. Toll-free (800) 525-5810.

7-12 Fifth Annual Postgraduate Course New Approaches to Clinical Problems in Internal Medicine—Snowmass Village, Snowmass, Colorado. Presented by the Department of Medicine, University of Colorado School of Medicine. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone (303) 394-5241.

8 Practical Management of Pain - Estes Park, Colorado. Speaker: Gerald A. Battersby, MD. CMS Category 1 hour AAFP prescribed credit: Two. Contact: Martin J. Rubinowitz, MD, The Denver

Clinic, 701 East Colfax Avenue, Denver, Colorado, 80203.

8-12 **The Denver Postgraduate Institute in Emergency Medicine: Pediatrics, OB-GYN & Surgical Subspecialties.** Contact: Janice Alexander, Denver Postgraduate Institute in Emergency Medicine, Emergency Medical Services, Denver General Hospital, West 8th & Cherokee, Denver, Colorado 80204. Telephone: (303) 893-7034

8-12 **35th Annual Meeting of the Northwestern Medical Association - Scientific/Ski Meeting.** Place: Sun Valley, Idaho. Credit: 10 CME Category I. Contact: Norman Christensen, M. D., Secretary, 2456 Buhne Street, Eureka, California 95501.

10-13 **21st Annual John R. Durrance Mid-winter Chest Conference** - Aspen, Colorado. 10 hours of AMA category 1 credit. Contact: Shirley Lindquist, American Lung Association, P.O. Box 921, Loveland, CO, 80539. Tel: (303) 667-5198.

11-13 **"Perspectives on New Diagnostic & Therapeutic Techniques in Clinical Cardiology: Exercise Testing Post Myocardial Infarction, Radionuclide Cardiac Imaging, 2-D and 3-D Echocardiography, Coronary Artery Spasm, Calcium Channel Blockers, Coronary Angioplasty, Thrombolytic Therapy, Coronary Surgery"** - Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista, Florida. Contact: Mary Anne McInerney, American College of Cardiology, 9111 Old Georgetown Road, Bethesda, Maryland 20841.

13-20 **OB/GYN** at Marriott's Mark Resort, Vail, Colorado (ACOG credit); **Psychiatry** at Lion Square Lodge, Vail; **Geriatric Medicine** at The Lodge at Vail. Contact: Beth Israel, Conference Program, P. O. Box 11366, Denver, Colorado 80211. (303) 629-5333. Toll-free (800) 525-5810

14-19 **Eighth Annual Winter Skin Seminar**—The Given Institute of Pathobiology, Aspen, Colorado. Contact: The Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East 9th Avenue, Box C-295, Denver, Colorado 80262. Telephone: (303) 394-5241

14-19 **Current Concepts in Pain Management & Current Concepts in Office Management (and the New Tax Law)** - Steamboat Springs, Colorado. Fee: \$250.00 plus \$150.00 per spouse. Contact: Current Concept Seminars, 9400 S. Dadeland Blvd., Suite 300, Miami, FL, 33156. Tel: (305) 666-0401

16 **Respiratory Therapy - Who, What, Why & When** - Salida, Colorado. Speaker: Thomas Reeder, MD. Category 1 hours & AAFP prescribed credit: Two. Contact: Martin J. Rubinowitz, MD, The Denver Clinic, 701 E. Colfax Avenue, Denver, Colorado 80203.

18-19 **New Horizons in Medicine** - Good Samaritan Hospital, Phoenix,

Arizona. Credits: 10 hours of Category I credit by AMA; 10 hours of Prescribed credit for AAFP. Contact: Imre Sandor, MD, Chairman, CME Committee, Good Samaritan Hospital, P.O. Box 2989, 1033 E. McDowell Road, Phoenix, Arizona 85062. (602) 257-4383.

18-20 **"Nuclear Medicine For Physicians and Technologists"**—San Diego, California. Contact: San Diego Radiology Research & Education Foundation, P. O. Box 2305, LaJolla, CA. 92038. Telephone (714) 453-7500, ext. 3711

20-27 **Pathology** - Kiandra Lodge, Vail, Colorado; **Radiology** - Aspen Institute for Humanistic Studies, Aspen, Colorado. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO, 80211. Tel: (303) 629-5333 or (800) 525-5810.

22-27 **28th Annual Family Practice Review - Postgraduate Course**—40 hours CME Category I credit. Fee: \$315.00. Contact: Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO. 80262. Phone (303) 394-5241.

23-27 **Bedside Approach to Cardiac Diagnosis** - Keystone, Colorado. Sponsored by Rose Medical Center. Category I credit & AAFP prescribed credit offered. Fees: \$365.00. Information: Dorothy Bailey, Office of Education, Rose Medical Center, 4567 E. 9th Ave., Denver, CO 80220. Phone (303) 320-2102.

25-28 **The 1982 Annual Meeting of the American Psychosomatic Society** - Brown Palace Hotel, Denver. Contact: The American Psychosomatic Society, 265 Nassau Road, Roosevelt, New York 11575 (516) 379-0191 or the Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver, Colorado 80262. (303) 394-5241.

26-28 **Extra Extracapsular Cataract & Anterior & Posterior Intraocular Lens Implant Course.** Place: The Waiohai Hotel, Kauai, Hawaii. Course Director: David S. Pfoff, MD. Fee: \$700.00 for didactic & lab; \$400.00 for didactic only. Contact: Colleen Requist, c/o Dr. Pfoff's office, 950 E. Harvard Ave., Suite 350, Denver, CO. 80210. Phone (303) 777-5457.

26-28 **Tenth Annual Taos Lung Disease Symposium** - Kachina Lodge, Taos, NM. Contact: New Mexico Chapter of the American Thoracic Society, 216 Truman NE, Albuquerque, NM. 87108. Phone (505) 265-0732.

Feb 27-Mar 7 **Cancer Treatment** -at Kiandra Lodge, Vail, CO.—Sports Medicine at Lion Square Lodge, Vail, CO. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO 80211. Phone (303) 629-5333; (800) 525-5810.

Feb 28-Mar 5 **Infectious Diseases and**

Rheumatology Course - The Givin Institute, Aspen, CO. Category I and AAFP Prescribed credit. Contact: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Denver, CO 80262. Phone (303) 394-5241 or 5195.

March

2-5 35th Annual Symposium on Fundamental Cancer Research "Perspectives on Genes & the Molecular Biology of Cancer."—Shamrock Hilton Hotel, Houston, TX. Information: Stephen C. Stuyck, Director, Public Information & Education, M. D. Anderson Hospital and Tumor Institute, 6723 Bertner Ave., Houston, TX 77030. Phone (713) 792-3030.

4-6 Third Annual Radiologic Technologists Course - San Diego, CA. Contact: San Diego Radiology Research & Education Foundation, P.O. Box 2305, LaJolla, CA 92038. Phone: (714) 453-7500, ext. 3711.

6-13 Family Practice at Marriott's Mark Resort, Vail, CO.—General Surgery at Lion Square Lodge, Vail—General Dentistry at Kiandra Lodge, Vail (AGD & ADA credit). Contact: Beth Israel, Conference Program, Box 11366, Denver, CO 80211. Phone (303) 629,5333, (800) 525-5810.

8-10 Gastroenterology for Clinicians - Learning in the Sun—Scottsdale, Arizona. AMA Category I and AAFP credit - 16½ hours. Contact: Mrs. David C. H. Sun, David C. H. Sun Memorial Institute, 4129 E. Sandy Mt. Road, Scottsdale, ARIZ. 85253. Phone: (602) 948-1064.

8-12 High Risk Infant Care - Postgraduate Course - Denver, Colorado. 34 Category I credit hours with 6 additional hours credit available for workshops. Fee: \$300.00 plus \$75.00 for workshops. Contact: The Office of Postgraduate Medical Education, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. Phone (303) 394-5241.

8-12 Poisoning: a Symposium - Denver, Colorado. Sponsored by the Rocky Mountain Poison Center, Denver, Colorado. 32.5 Category 1 AMA credits. Tuition: General Session -\$305 for physicians if postmarked by 1/15/82, \$320 if later; \$210 for nurses & pharmacists if postmarked by 1/15/82, \$225 if later; Special Seminar \$75 (Current Trends in Drug Therapy); Special Seminar \$40 (Poison Center Management of Common Poisonings); Toxicokinetics Workshop \$25. Contact: Director of Professional Education, Rocky Mountain Poison Center, West 8th & Cherokee St., Denver, CO, 80204. Tel: (303) 893-7774.

8-12 Sports Medicine, Postgraduate Course in: - Maui, Hawaii. Sponsored by the Northwestern Center for Sports Medicine. The course has been planned to coincide with the Maui Marathon and will carry 25 hours of Category 1 CME credit. Contact: Bates Noble, MD, Couse

Director, Northwestern University Center for Sports Medicine, 303 East Chicago Ave., Chicago, IL, 60611.

13-20 Internal Medicine - Lion Square Lodge, Vail: **Pediatrics** - Marriott's Mark Resort, Vail: **Clinical Brain** -Kiandra Lodge, Vail Colorado. Contact: Beth Israel, Conference Program, P.O. Box 11366, Denver, CO, 80211. Tel: (303) 629-5333 or (800) 525-5810.

14-19 Third Annual Mammoth Mountain Emergency Ski Conference - Mammoth Lakes, Professor: John A. Herring, MD, Dallas, Texas. Credit: AMA Category 1, AAFP approval applied for. Contact: Robert E. Eilert, MD, 1056 East 19th Ave., Denver, CO, 80218. Tel: (303) 861-6600.

21-28 St. Moritz 1982: Advances in Diagnostic Imaging - Palace Hotel, St. Moritz, Switzerland. Contact: Edward A. Eikman, MD, Associate Professor of Medicine, University of South Florida, College of Medicine, Veterans Administration Hospital, 13000 North 30th St., Tampa, FL 33612. Tele: (813) 974-2032.

23-26 Gastrointestinal Radiology with Emphasis on Imaging & Invasive Techniques - San Diego, California. Contact: San Diego Radiology Research and Education Foundation, P.O. Box 2305, La Jolla, CA 92038. Tele: (714) 453-7500, ext 3711.

April

16 Children's Orthopedic Day - The Children's Hospital, Denver, Colorado. Visiting Professor: John A. Herring, MD, Dallas, Texas. Credit: AMA Category 1, AAFP approval applied for. Contact: Robert E Eilert, MD, 1056 East 19th Ave., Denver, CO 80218. Tele: (303) 861-6600.

Apr 25-May 3 4th Annual Current Concepts in Musculoskeletal Radiology and Orthopedics -Athens, Greece. Sponsored by the Mallinckrodt Institute of Radiology and the Department of Clinical Therapeutics of the Athens University Medical School. Contact: Luis A. Gilula, MD, Mallinckrodt Institute of Radiology, 510 South Kingshighway Blvd., St. Louis, MO, 63110.

28 Fingertip Repair - Julesberg, Colorado. 2 hours CMS Category 1 and AAFP prescribed credit. Contact: Martin J. Rubinowitz, MD, The Denver Clinic, 701 East Colfax Ave., Denver, CO, 80203.

May

16-20 Fifth International Symposium on the Prevention & Detection of Cancer - Sao Paulo, Brazil. CME Credit hours are arranged for U.S. participants. Contact: Medical Congress Coordinators Dept., 1212 Avenue of the Americas, New York, NY, 10036. Phone: (212) 840-0110.

Women's Health Conference Returns

"Provocative topics...such as parenting, birth control, etc." are to be offered at the 1982 Conference on Health Concerns of Women. Last year's conference, which was attended by 180

women and which resulted in May 9th being proclaimed Women's Health Day, was an unqualified success, according to all involved. This year's conference promises to be even better. After last year's day-long program, participants were polled as to the effect the conference would have on "assumption of responsibility for personal health." A majority commented favorably, leading the Planning Committee to conclude that the conference had been effective in fulfilling the goal of patient education — a major priority of the 1980-81 CMS program year.

In 1981-82, even greater emphasis has been placed on patient education and self-responsibility. In an effort to implement this priority, the CMS Board of Directors and Council on Public Health have decided to repeat last year's experience with a second Conference on Health Concerns of Women.

The 1982 conference is still in the planning stages — date and location have yet to be confirmed. However, the general format of the conference should be the same as last year's: a one and one-half hour morning session at which participants will choose one of several available workshops, a one-hour lunch break (lunch included in the registration fee), an afternoon session where the participants will attend a second workshop, and a wrap-up session at the end of the day.

This year's conference will be planned to attract younger women in greater numbers than last year;

with this in mind, the planning committee is encouraging participation of younger members of the co-sponsoring organizations. (For a list of these, see below.) The conference will probably be held on a Saturday, as before, and an in-town site has been suggested, with the addition of daycare for young children. Specific

attention is being given to topics answering younger women's needs. Finally, publicity is being considered which will carry the message of

the conference to "minority communities, college campuses, well baby clinics, etc., in addition to the state-wide women's organizations most involved in the conference."

Patient education received a shot in the arm from the first conference; it is due for a booster with the second. The concept of the conference has been refined while the scope has been expanded. The Planning Committee is eager for reaction from the physician community. Your own patients could probably benefit from such a program — referrals are encouraged.

Organizations participating in the 1981 Conference on Health Concerns of Women:

Colorado Medical Society Council on Public Health — Colorado Medical Society Auxiliary — Colorado Chapter of the American Medical Women's Association — Colorado Federation of Business and Professional Women — Colorado State Division of the American Association of University Women — Colorado Parent, Teacher, Student Association — Colorado Federation of Women's Clubs — Colorado Church Women United — Delta Kappa Gamma — Colorado Hospital Association Auxiliary — Colorado Nurses Association.



Elinor T. Christiansen, MD (l.) and Kathy Thompson, Planning Committee Co-Chairmen.



Grievance of the Month

Complaint: Mr. XXX complains to the Grievance Committee that Dr. YYY refused him service because Mr. XXX would not fill out a "new patient information" form and would not pay at the time of service.

Investigation: Upon request by the Grievance Committee, Dr. YYY responded that Mr. XXX was excessively demanding and rude and that the patient indeed "refused to be served" after knowledge of the office policies.

Disposition: Mr. XXX was informed by the Grievance Committee that both the payment and information policies were common practice and useful in patient care. Furthermore, they explained to Mr. XXX that, in their opinion, he had been unreasonable and his complaint was unjustified.

Comment: In this particular case, the Grievance Committee functions as a supporter of a Colorado physician.

Petty, Rainer Elected to National Specialty Society Offices

ACCP's 47th Annual Scientific Assembly sees installation of President and President-elect



Thomas L. Petty, MD, FACP, was installed October 28, 1981, as the President of the American College of Chest Physicians at the ACCP's 47th Annual Scientific Assembly in San

Francisco. Dr. Petty is professor of medicine and anesthesiology at the University of Colorado School of Medicine, head of the division of

pulmonary medicine and director of the respiratory care unit. Dr. Petty also serves as a consultant to the Veterans Administration Hospital and Fitzsimmons General Hospital.

A noted pulmonary physician and a Fellow of the American College of Chest Physicians since 1969, Dr. Petty most recently served as Chairman of the Board of Regents and Chairman of the Postgraduate Medical Education Committee. He is an associate member of the American Board of Internal Medicine and a member of the Pulmonary Disease Subspecialty Board. He is a noted author, with over 100 major scientific papers published in almost every leading journal, and has authored six books. He currently serves on the editorial board of the *Western Journal of Medicine*.



At the same Scientific Assembly the ACCP announced election of William Gerald Rainer, MD, FACP, as its new President-elect. Dr. Rainer is clinical professor of surgery at University of Colorado School of Medicine and chief of the section of thoracic and cardiovascular surgery at St. Joseph Hospital in Denver. He is attending thoracic and cardiovascular surgeon at the Denver General Hospital, Colorado General Hospital and the Veterans Administration Hospital. He also serves as a surgical consultant to several other Denver hospitals.

Dr. Rainer has been a Fellow of the ACCP since 1965 and has taken a great deal of interest as associate director of the ACCP's International Activities. He is past president of the Colorado Heart Association, Colorado Trudeau Society, Denver Academy of Surgery, Denver Medical Society and is currently a member of the Board of Directors of the Colorado Medical Society. Author of over 70 scientific articles, Dr. Rainer has also presented numerous exhibits and motion pictures to medical conferences. He has been an invited guest lecturer at the University of Santa Tomas Medical School (Manilla, Philippines), Heart Association of Thailand (Bangkok), University of Lisbon (Portugal), Ain Shams

University (Cairo, Egypt), and in Kwang Chow, Shanghai and Peking in the Peoples Republic of China.

Highlights of Minutes

Board of Managers, Colorado Consortium for Continuing Medical Education, October 21, 1981

Charles Marcus, Executive Director, Department of Program Administration, CMS, presented the Board with the projected costs of operating the Consortium to the end of the fiscal/calendar year, and the Consortium's financial statement through September 30th.

The Board also approved a draft of the Guidelines for the Forum on Continuing Medical Education. This draft will be finalized and approved at the next meeting of the Board.

Teleconference II is underway.....

.....but it's not too late to sign up. Interested hospital staffs will be given a pro-rated fee if they choose to take advantage of the four remaining one-hour, Category 1 accredited, educational programs scheduled for January through April, 1982.

The programs will be given via the Tele-Net system, on the third Friday of each month, 7:30 - 8:30 a.m. Handouts and slides will be sent to each site before the presentations. All participants will have a chance to ask questions and make comments. There is no limit on the number of participants from each hospital.

For information on the topics coming up, cost of the programs, and how to sign up, please call Clyde Tucker, MD, Director, Office of Educational Services, University of Colorado Health Sciences Center, 394-7307.

Professional Education Update

An Approach to the Control of Carcinoma of the Endometrium. S.B. Gusberg, MD. A practical approach to the management of the increasingly critical problem of endometrial cancer is discussed by one of the specialists in the field. Dr. Gusberg's description of high-risk patients, tips

Impaired Physician Program Available

CMS has an impaired physician program to help physicians before they endanger their patients or themselves.

A few years ago the CMS Board of Directors received a charge from the House of Delegates to create a program designed to aid impaired physicians — to help them confront their problems and find treatment. The Physician Health and Rehabilitation Committee works as an advocate — not in a punitive manner.

Those who know of a colleague who may have a problem, or who need help themselves, should contact the Committee at the CMS office in Denver, 861-1221.

on the identification of pre-cancerous lesions and suggestions for treatment according to stage of disease should be of great interest to any physician called upon to diagnose, refer or treat women with endometrial cancer.

Carcinogens in the Workplace. David M. Schottenfeld, MD and Joanna F. Haas, MD. This detailed discussion answers all questions related to carcinogens in the workplace, including methods of epidemiological research, relevance of animal studies in predicting risk and current measures for prevention and control. A seven-page table lists industrial agents with associated or suspected carcinogenic potential. Of great public interest, *Carcinogens in the Workplace* is a valuable addition to the physician's reference file.

Three County Jails Accredited by AMA Through CMS

Three Colorado jails have been accredited by the American Medical Association for meeting uniform standards of inmate health care. Governor Richard Lamm met with officials of the Boulder County Jail, Pueblo County Detention and the Mesa County Jail, to present the American Medical Association cer-

tificates of accreditation, November 12 at the State Capitol Building.

The mission of the CMS Jail Health Care Project is four-fold: first, to evaluate and assess current health care delivery in Colorado jails; second, to establish and implement replicable models for delivery; third, to provide training and technical assistance to jail personnel in health care delivery; and fourth, to implement a national accreditation program for medical care and health services in jails. The three jails that have received accreditation, each different in its requirements, will each serve as a model of care delivery for other similar jails.

Boulder County Jail has been able to utilize a licensed physician who practices in that local community to act as the health authority. Reporting to him is a jail health care staff which consists of registered nurses on duty daily.

Mesa County Jail is using a different program of public health nurses supervised by the public health nursing director and the county health director. Nurses are on duty seven days a week.

Pueblo County Detention Facility contracts with a physician as the health authority to supervise a house staff of emergency medical technicians as "medics" on a 24 hour, 7 days a week basis. Each of these health systems was found to be in significant compliance with the Standards and each was awarded a 2 year accreditation status by the AMA.

Ten Colorado jails have participated in the 10-month long project of assessment of jail health standards. The Colorado Medical Society, through the work of the Committee on Medical Care in Correctional Institutions (John V. Buglewicz, MD, Chairman) and County Sheriffs of Colorado (Jim O'Neil, Executive Director) recognized the need for such a program in Colorado. The Colorado Medical Society has provided both funds and personnel for the assessment program and for training seminars and administrative aid. Attending the Governor's presentation of the accreditation certificates was Robert Moore, Medical Director of the Colorado Correctional Complex (Colorado

State Penitentiary), Canon City, Colorado. Mr. Moore has worked closely with the CMS Committee on Medical Care in Correctional Institutions, realizing early that many of the county jail inmates were to eventually be sent to the penitentiary. Dr. Buglewicz and Bob Moore saw that improved early diagnosis of health problems and care at the jail level of detention would have a direct effect on the inmate health at the penitentiary, itself limited in the amount and type of medical care which could be provided.

Participation in this project was voluntary, and these institutions deserve much credit for willingly working, rapidly and without pressure from inmates or special interest citizen's groups, to improve the care and treatment of their inmates. Colorado Governor Richard Lamm felt strongly enough of the strides taken in improving inmate conditions that he honored the officials of the detention facilities and the members of CMS and other participants in presenting the AMA accreditations in his offices.

(Continued on p.457)



Colorado Governor Richard Lamm joins with officials of the Colorado Medical Society and three county detention facilities in presenting AMA Jail Health Standards Accreditation Certificates, following a ten-month assessment and training program of ten such county jails. L to r, Boulder County Sheriff Brad Leach, Christine Wilson, current CMS Jail Health Care Project Coordinator, Jim O'Neill, Exec. Director, County Sheriffs of Colorado (representing Sheriff Leslie R. Williams, Mesa County), John V. Buglewicz, MD, Chairman, CMS Committee on Medical Care in Correctional Institutions, Governor Lamm, Robert Moore, Medical Services Director, Colorado State Penitentiary, Kathleen Gueymard, former CMS Jail Project Coordinator, and Pueblo County Sheriff Dan Tihonovich.

American Association of Medical Assistants, Inc.

Colorado Society — Capitol Chapter

“Child Abuse — Our Responsibility”

Saturday, January 9, 1982

9:00 am - 2:00 pm

Humphreys Auditorium

University of Colorado

Health Sciences Center

Speakers: • John Sheppard, Investigator, Arapahoe County Sheriff's Department
• Ed Nelson, Sheriff, Arapahoe County

8:30 am - 9:30 am.....Registration
9:00 am - 11:00 am.....Speaker
11:00 am- 12:00 Noon.....Luncheon Break
(A BOX LUNCH WILL BE SERVED)
12:00 Noon - 2:00 pm.....Speaker

Continuing Education Unit credit has been applied for. Registration Costs: \$20.00 members, \$25.00 non-members. Registration costs include box lunch. Those attending who wish to have CEU credit will be charged \$2.00 for members and \$3.00 for non-members for CEU registration.

Make checks payable to: Capitol Chapter Colorado Society of Medical Assistants

Mail registration to:

Boni Bruntz CMA-A

13641 East Dakota Ave.

Aurora, Colorado 80012

Home phone: 343-0163

Office: 761-2870

Registration Form

AAMA Colorado Society, Capitol Chapter — “Child Abuse: Our Responsibility”

Name _____ Member ☐ Non-member ☐

Address _____ Zip Code _____

Home Phone _____ Work Phone _____

Social Security No. _____

Registration Deadline January 6, 1982

Physician Task Force to Change Patients' Life Styles

Changing patients' life styles or way of living has long been a challenge for physicians. It has been the subject of discussion and preparation for over a year by the *Task Force on Health Enhancement* of the Denver Medical Society. Task Force members have produced a document speaking to various aspects of a patient's way of life which has been reviewed and approved by the Board of Directors of the Society.

The essays are, in effect, position papers on the following topics:

- Alcohol
- Drugs
- Exercise and Cardiovascular Activities
- Nutrition
- Motor Vehicle Safety
- Periodic Physical Examination
- Stress

The document recognizes that many people today are assuming self-responsibility for crucial factors affecting health. They are also recognizing the evidence that living habits influence the quality and duration of life. However, it is the feeling of the Task Force and the Denver Medical Society that expanded efforts in health enhancement are necessary to further reduce premature death and illness resulting from major diseases such as stroke, chronic pulmonary disease, smoking-associated cancers and others which constitute major medical and economic burdens for Americans.

The Denver Medical Society is publishing the document for distribution to its members. A limited number of additional copies is being made available to members to give to patients or to place in doctors' waiting rooms. Further distribution to other physicians in the state and to the general public awaits additional funding.

(Continued from p. 455)

The end of the project did not mean the end of the participation by

the ten jails, even though only three of them have received their accreditation from the AMA at this time. The Colorado State Legislature has seen fit to contract for a continuation of this health care standards accreditation program through the Colorado Medical Society for the coming year. This will consist of the CMS coordinator continuing the assessment of the state's jails and recommendations as to how the AMA-level accreditation can be achieved; further, the CMS coordinator will continue with the scheduling and implementing of workshops or seminars for jail personnel to achieve the standards of health care, as set forth in the AMA-LEAA program.

CMS has been very much in favor of raising and standardizing health care levels in all such public institutions. The Jail Project has been well received by jail personnel and has indicated the need for an on-going program of instruction, facility assessment and accreditation. The Colorado Medical Society is very pleased to be working with the State of Colorado in such a continuing program.



Rehabilitation Groups of the American Cancer Society Laryngectomy Association

With the approval of the attending physician, trained volunteers who have had laryngectomy surgery, visit the patient. Personal experience and compassion enable the volunteer to communicate emotional support for learning to speak again. No medical advice is given.

For more information

American Cancer Society
Colorado Division, Inc.
321-2464

VE Futures Statement Published

The Colorado Voluntary Effort Committee has formulated a policy statement to "promote cooperation" among health care providers and purchasers.

The Voluntary Effort to contain health care costs, or VE as it's more commonly known, was initiated in late 1977 as a response to growing concern over the spiraling increase in health care costs. It arose as an industry proposed alternative to regulatory legislation then under consideration by the the Carter administration. In this sense it represented a unique development since it was the first time segments of the private sector voluntarily organized themselves into a body for controlling their own costs.

A National Steering Committee (NSC), comprised of representatives of the major actors within the health care arena, was formed to guide the goal-setting of the organization at the national level, and to promote the development of state and local VE organizations to adopt and carry out the objectives at the grassroots level. Representatives in the NSC included: The American Hospital Association, the American Medical Association, the Blue Cross and Blue Shield Associations, the Federation of American Hospitals, the Health Industry Manufacturer's Association, the Health Insurance Institute of America, the National Association of Counties, Virginia Knower and Associates (consumer representatives), and the business community.

The initial thrust of the VE's activities was aimed at short term cost containment, but has been expanded to include long-range efforts to create a more cost effective health delivery system. In the years 1978 and 1979, largely as a direct result of the VE, the rate of increase in health

care costs was held at or below the increase in the "all items" category of the Consumer Price Index. Since 1980 the gap in the increase between health care costs and costs in general has begun to widen once again, emphasizing the need for greater concentration of effort to develop effective cost containment strategies and to promote the activities of the VE at the state level.

In Colorado, the state-wide VE Committee was modeled after the NSC. The Colorado Voluntary Effort includes representatives of a broad spectrum of agencies and institutions involved in, or concerned with, the issue of cost containment in the health care field.

The official purpose of the Colorado VE is "to direct and guide the development of a voluntary coalition of providers and consumers to contain health care costs and evolve strategies for structuring a more appropriate and cost efficient quality health care system."

Among the activities with which the VE is currently involved are several committees whose purpose is to develop detailed action plans in light of the Futures Statement that the VE recently completed. The specific committees are: Peer Review, Consumer Information Task Force, Ambulatory Surgical Centers, and Insurance Co-Payments. The Futures Statement was developed to reflect the concerns of the various groups represented on the VE — consumers, business, labor and providers — over the important trends and directions of health care in Colorado. The Futures Statement is presented in its entirety below.

Colorado Voluntary Effort Futures Statement

Preface

Recognizing the seriousness of the problems and challenges involved in the delivery of health care services in Colorado in the 1980's, the diverse membership of the Colorado Voluntary Effort Steering Committee feels that a consensus statement about the future would promote cooperation among the concerned groups. In reaching the conclusions that follow, the Committee assumed the continuation of most elements of the current health financing and delivery system, but did try to consider the impact of some clearly emerging trends. It is the hope of the Committee that a shared view of the future will lead to discussion of the key issues and finally to cooperative planning and action to shape a quality and cost effective health system for Colorado.

Demand for Services

The demand for health services in Colorado will continue to increase during the 1980's, driven by population growth (especially along the Front Range and in energy-impacted areas of the Western Slope), the aging of the population, the increase in the supply of physicians and advances in medical knowledge. This increased demand for services will be scrutinized by payors and intermediaries. Ineffective past efforts to control costs by controlling supply will be supplemented by efforts to control demand. Greater emphasis on preventive services, alternative delivery system, health promotion and wellness programs and sharing of direct payment by consumers may reduce demand for some population sub-groups.

Supply of Services

The growing supply of physicians in Colorado will continue well into the future. There will also be an increase of other health care professionals to compete independently with physicians for a limited number of health care dollars. As a result of cut-backs in government funding some health care services will be reduced. Alternative delivery systems will be formed, and new forms of health care systems will likely emerge to fill the gap between

acute hospital care and nursing home care.

Prices

Prices paid for health care services will continue to rise faster than general inflation in Colorado. Increased use of technology, improved treatments and higher utilization by aging populations coupled with Medicare and Medicaid cut-backs will shift more of the costs to non-government purchasers of care. Efforts to reduce the total health bill of Colorado and the nation in relation to the Gross National Product and per capita income will result in higher per unit prices. As price increases are felt directly and indirectly by purchasers and consumers there will be increased demand for price and charge accountability, competition, trade off of health benefits for increased salary, formation of purchasers' coalitions, and development of innovative reimbursement mechanisms.

Physicians

With the increased supply of physicians (and the maldistribution between the rural and urban areas of Colorado) there will be severe economic constraints on young physicians entering practice. Reduction of government support to medical schools will result in declining enrollments. More physicians will find advantages in joining prepaid programs and there will be more hospital-based physicians, corporate practice including specialty group practice and multi-specialty clinics. Limited funds for reimbursement will create more competition and likely decrease per physician income, and other health professionals may be utilized where appropriate. Payors and patients will have increased input into the physician's pattern of practice as they ask him to respond to cost issues. Expensive diagnostic and therapeutic procedures will require solid justification. These circumstances will lead to new, interactive working relationships between hospitals and physician groups.

Hospitals

Hospitals in Colorado in the 1980's could be caught in the squeeze between increased demand and reduced government reimbursement, unless they can find acceptable ways of shifting the pay-

ment load to other health care payors. Other shifting emphases that hospitals will face include moves from free-standing, independent institutions to various multi-institutional alliances (for-profit corporations, satellite facilities, increased specialization, etc.) and moves from inpatient services to outpatient services. Expansion of services and the building of new hospitals in metropolitan Denver will be influenced as much by access to capital as by certificate of need. Management effectiveness, marketing, productivity, and adequate funds for growth and development will determine the long-range economic viability of hospitals. Competition (especially without changes in the inequitable Medicare/Medicaid reimbursement system) may close some hospitals, thus reducing choices for physicians and patients. Hospitals will need to develop more effective working relationships with groups of physicians especially in the areas of utilization, cost containment, and reimbursement.

Government Purchasing

Government purchasing will shift from the federal level to increased purchasing capacity at the state level; however, Medicare will continue to be a major purchaser of health care services. As state and local institutions play a larger role, some consumer choices may be narrowed. Changes in government purchasing will take the form of a "prudent purchaser" approach with government-as-purchaser doing more bargain hunting and becoming a much more aggressive buyer. As the federal government seeks ways to reduce its payments, it may explore negotiating directly with providers to trade a guarantee of a minimum volume of care for lower per capita pay-out. A prospective capitation basis of payment is one option that may develop into a viable payment mechanism. More dollars will be made available for alternatives to institutional care and fewer dollars will be available for hospital and nursing home care.

Business Purchasing

Employers will look more to other alternatives to the delivery of health care rather than the acute care system and will also look increasingly to new payment mechanisms. The

effect of business purchasing will promote competition in the health care system and will move the system toward a supply and demand model. Business purchasing will incorporate incentives into employee benefit programs to reduce demand.

Third Parties

Third party payors will make various attempts to control demand for health care. Benefits packages will be directed away from comprehensive first-dollar coverage, will be designed to substitute ambulatory for inpatient care, and will attempt to shorten expensive inpatient stays. More limitations and exclusions will be developed in an effort to avoid medically unnecessary or inappropriate use of services, and utilization review programs will be expanded. Third party payors will encourage more participation on the part of the consumer and will develop and disseminate subscriber-oriented educational materials as well as account-specific statistical reports. In line with increasing interest in prepaid medical care, third party payors will become more involved in the sponsorship of HMOs.

Technology

In the 1980's, we will realize we cannot afford unlimited or inappropriate utilization of technology and services, and the quality versus cost dilemma will become the main force for systemwide change. The previous drive of being the first with the biggest and best will give way to more critical scrutiny of available technology. Greater emphasis will be seen on cost feasibility studies and general business plan approaches, and cost benefit analysis will become a more significant part of the decision process.

Consumers

Consumers will become more knowledgeable about medicine and hospital services. They will become much more of an advocate for their position and voice in the decisions related to the delivery of health care. The scarcity of resources will chip away at Americans' "right to health care," and consumers will probably experience a reduction in the range of choices in available services. They will see benefits reduce, especially through higher co-pays and deductibles, and wellness and disease prevention may become an economic necessity.

Drug Therapy: Questions & Answers

Christopher S. Conner, Pharm.D., Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; Dennis R. Sawyer, Pharm.D., Associate Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center; Earl Sutherland, MD, Ph.D., Medical Director, Rocky Mountain Drug Consultation Center, Attending Physician, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center.

This bi-monthly column is designed to provide Colorado physicians with specific answers to commonly asked questions regarding drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column were generated from calls received by the Rocky Mountain Drug Consultation Center from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the

Denver metro area or 1-800-332-6475 in Colorado for specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure, and drug identification. The Center is available from 8:00 a.m. - 8:00 p.m. Monday through Friday, with 24 hour on-call service.

DISULFIRAM-LIKE REACTIONS TO DRUGS

Request:

What other drugs could cause a disulfiram (Antabuse[®]) reaction with alcohol?

Response:

The disulfiram-alcohol reaction is a well-known clinical phenomenon. Less well-known, however, is that a disulfiram-like reaction may occur with many other drugs. This report describes recent reports of disulfiram-like reactions with other medications or disease states. Reactions are divided into three categories (clinically significant, probable and possible) based upon evaluation of literature for incidence, severity and significance of reports.

Clinically Significant Reactions. The following drugs have been documented to cause the disulfiram reaction:

1. Cephalosporins (McMahon, 1980; Foster et al, 1980; Portier, 1980; Drummer et al, 1980) (cefamandole/cefoperazone)

Recently, two parenteral cephalosporins have been reported to cause a significant disulfiram-like reaction. Portier et al (1980) reported a 68 year old man who experienced a severe peripheral flush with shock 30 minutes after drinking wine. He had been receiving cefamandole 750 mg IV every 8 hours for the previous six days. The reaction was repeated 48 hours later when he drank wine.

Drummer (1980) reported a similar reaction to cefamandole in a 25 year old woman who drank four sips of chablis wine 3½ hours after the IV dose. The patient refused to be rechallenged with alcohol.

McMahon (1980) noticed that several subjects in a kinetics study of cefoperazone, an experimental

cephalosporin, experienced facial flushing and tachycardia after drinking one or two glasses of beer. Five other subjects in the study were then challenged with 15-20 oz. of beer 36 hours after their last infusion of cefoperazone. All five experienced facial flushing and tachycardia.

Foster et al (1980) reported a 24 year old man who experienced a disulfiram-like reaction 25 hours after a 3 gm IV dose of cefoperazone within 15 minutes of drinking 12 oz beer and had a similar reaction lasting 1.5 - 2.0 hours. A third challenge five hours later with six oz. of beer produced an identical reaction which abated rapidly.

2. Chlorpropamide/Tolbutamide

A disulfiram-like reaction has been documented to occur with chlorpropamide and, to a lesser extent, with tolbutamide. Although there are no reported reactions to any of the other sulfonylureas, it is advisable to avoid alcohol with them also.

Facial flushing, palpitations, and headache has been reported to occur in up to 60% of patients receiving chlorpropamide and ingesting even small amounts of alcohol. The reaction is not related to acetaldehyde buildup and apparently is due to an abnormal response of small blood vessels to chlorpropamide. This tendency may be inherited as an autosomal dominant trait in association with maturity onset diabetes. It is infrequently found in juvenile onset diabetes (Anon, 1976; Leslie, 1978; Hanson, 1979). Recent data, however, suggests that the facial flush induced by alcohol ingestion is not specific for non-insulin dependent diabetes (NIDDM) and that this test is not useful as a genetic marker for diagnosis of dominantly inherited NIDDM (Kobberling et al, 1980).

3. Procarbazine

The ingestion of alcohol by patients taking procarbazine has resulted in intense facial reddening and other disulfiram-like symptoms. Procarbazine is an MAO inhibitor which may account for the reported reactions to wine or beer, which contain tyramine. But there are also reactions reported to mixed drinks (Gilman et al, 1980; Elenbaas, 1979).

4. Mushrooms

The ink cap mushroom (*Coprinus atramentarius*) is an edible mushroom recognized by its black spores, smooth grayish pileus, and gills which exude a dark-colored fluid as the spores are discharged. This mushroom contains a chemical (bis-diethyl-thiocarbamoyl-disulfide) which interacts with alcohol to produce a mild disulfiram reaction (Claus et al, 1970).

5. Disease States

Certain individuals have an inherent tendency to flush in the facial areas, especially in response to alcohol, coffee, very cold or hot drinks, and highly spiced foods. In rosacea, the flush becomes permanent and marked, usually after the age of 40. Patients with rosacea display an intense erythema of the face and abdomen upon consumption of alcohol (Pillsbury & Heaton, 1980; Wilkin, 1980).

Possible Reactions. These drugs have been reported to cause a disulfiram-like reaction, but occurrence is rare:

1. Griseofulvin (Hansten, 1979)
2. Metronidazole (Anon, 1976)

Recent well-controlled studies have not substantiated early reports of a disulfiram-like reaction following alcohol ingestion. In vitro studies show that metronidazole does inhibit aldehyde dehydrogenase, but animal studies have not confirmed this.

A double-blind crossover study (Gelder & Edwards, 1968) did not find significant effects of the drug on blood pressure, pulse rate, or autonomic side effects after a challenge drink.

Potential Reactions. These drugs inhibit aldehyde dehydrogenase to varying extents and may or may not cause a reaction (Azarnoff & Hurwitz, 1970; Dukes, 1977):

1. Chloramphenicol
2. Chloral Hydrate
3. Furazolidone
4. Nitrofurantoin
5. Quinacrine
6. Phentolamine/Tolazoline
7. Sulfonamides

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Rocky Mountain Drug
Consultation Center



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An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinintex® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. **Gastrointestinal** symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transiently abnormal results in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[continued]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.⁸

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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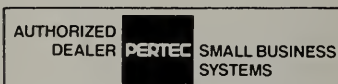
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Public Information Grievance Procedure:

How It Works

(ED: The Colorado Code of Cooperation Committee, a group representing physicians, hospitals and the public news media, created a grievance procedure in 1979 for the benefit of participants in the Code. This article is a complete reprint of the testimony and the conclusions of the Grievance Committee.

Though the testimony is lengthy, it was felt important enough in medical and health care reporting that the entire hearing transcription be published.

One of the primary considerations of this committee became the matter of the 'Inglefinger Rule,' the code of the New England Journal of Medicine which rules that no article be published in that scientific journal if the article or related information had appeared in any other publication.)

A Grievance Committee appointed by the Colorado Code of Cooperation Committee met at 2:30

p.m., Wednesday, October 7, 1981, at the Denver Press Club to hear the formal complaint by the Denver Post against the University of Colorado Health Sciences Center.

The Colorado Code of Cooperation Committee is an informal committee of representatives from hospitals, physicians and news media that develops public information guidelines for mutual cooperation among the three entities. The Committee is a recommending body and has no statutory authority.

As a result of this Post-UCHSC hearing, a meeting of the Code Committee will be held at a later date to discuss some of the issues raised by the grievance. Notices will be sent to all Committee members.

The following is a transcript of the hearing proceedings as recorded:

Members of the Code of Cooperation Committee present:
Sherry Hartman, President
Bill Pierson, Secretary-Treasurer

Members of the Grievance Committee:

Robert E. O'Haire (Mercy Medical Center), Chairman,
Meindert Bosch (Administrator, Bethesda Hospital)
Jim West (Managing Editor, KOA News)

Thomas H. Coleman, MD (Communications Committee, Denver Medical Society)

Z. James Czupor (Denver Dept. of Health and Hospitals)

Representing The Denver Post were:
Chuck Green, Assistant Managing Editor, Denver Post

Bill Symons, Medical Reporter, Denver Post

Gay Cook, Assistant City Editor, Denver Post

Representing UCHSC was:

Tom Reese, Media Relations Director, UCHSC

Hartman: My name is Sherry Hartman. This year I am the President of the Colorado Code of Cooperation Committee. For anyone who might not understand what this committee does, the Code of Cooperation Committee was organized in 1946 to facilitate cooperation between the hospitals, physicians and the news media. In 1979, a grievance procedure was adopted and this is the first time that a grievance has gone all the way to a hearing. I would like to read to you the purpose of having public relations and public information guidelines for hospitals, physicians and the news media. This is taken from the introduction:

'This guide is an attempt to balance the public's right to certain information with hospital, physician and patient rights. It should be tempered by sound judgement, recognition of special circumstances, knowledge of local conditions and a generous dose of common sense.'

The organizations that participated in the revision of these latest guidelines were the Associated Press, Colorado Broadcasters Association, Colorado Department of Health, Colorado Department of Institutions, Colorado Medical Society, Colorado Press Association, Colorado Hospital Association, Denver Department of Health and Hospitals, Denver Medical Society, The Denver Post, Metropolitan Denver Hospital Council, University

of Colorado Health Sciences Center, Colorado Society of Osteopathic Medicine, Sentinel Newspapers, Colorado Hospital Society for Public Relations, and the Radio-TV News Directors Association.

As President, I was to appoint a Grievance Chairman who then selected a committee with the majority of the committee from hospitals. The members are: Minderd Bosch, Administrator of Bethesda Mental Health Center and Hospital; Dr. Thomas Coleman, Chairman of the Communications Committee of the Denver Medical Society and editor of the Denver Medical Society Bulletin, substituting for Robert A. O'Dell, MD, who could not participate today; Mr. Robert O'Haire, Director of Development and Community Relations, Mercy Medical Center, Chairman of the Grievance Committee; Jim West, Managing Editor, KOA-TV News; James Czupor, Director of Education and Community Relations, Denver General Hospital.

O'Haire: On your agenda we would also like to add after the two presentations a minute or two for the reaction from and to, or also from the committee. That will follow the presentations by both the Post and the Health Sciences Center. Then, after the questions by both, with a ten minute maximum, there will also be time for reaction. At the end, also.

As you see, the time limits are given: 15 minutes maximum for each of the formal presentations. On the questions, 10 minutes. We do have a stop watch, so will stop you at the appointed time. So that everyone is completely clear about what the grievance concerns, I would like to read you the letter written by Chuck Green, Assistant Managing Editor of the Denver Post, to Sherry (Hartman) on August 7th of this year:

Dear Ms. Hartman: This letter is a formal protest under the provisions of the Colorado Code of Cooperation of the refusal by the University Hospital and the University Health Sciences Center News Media Relations Office to provide information about the condition of a patient. The Denver Post has made repeated inquiries to the hospital's patient information service and news media rela-

tions office about the condition of a baby boy, born July 16th, 1981, to a woman whose name the Denver Post agreed not to reveal. Although the doctors involved and other official sources have refused to provide or confirm facts about prenatal surgery performed on the mother and baby, The Post has printed news articles June 28th and July 30, 1981, reporting on the importance of the procedure, a pioneering and unique achievement. The nature of the surgery has made the occurrence newsworthy, placing the mother and baby, the Post believes, in the category of public persons. The request for condition reports, and this protest, are based on the following paragraph under 'Public Figures' in the Code of Cooperation: "There are times when circumstances create a famous person out of an ordinary citizen (an organ transplant, for example). Under certain circumstances, this person may become a public person and give up certain personal privileges."

On this basis, the Post requests that the Code of Cooperation Committee intervene in this matter. The Post would appreciate a report on this in a timely fashion.' (Signature: Chuck Green, Managing Editor).

First on the agenda, then, is a presentation by The Denver Post, with a 15-minute maximum:

Green: Thank you Bob. My name is Chuck Green, and I am the Assistant Managing Editor of the Denver Post. First, I would like to express my gratitude to everyone here for the time they have devoted to this dispute. I'd like to introduce Bill Symons, sitting next to me, who is the reporter assigned to this story, and Gay Cook, the Assistant City Editor assigned to handle the preparation of the article and to get it in the newspaper. At the outset I'd like to make it clear that we have no dispute with Tom Reese, who is put in a rather awkward position of defending the policies of the Medical Center. I've known Tom for many, many years. I have no problem with his professional ethics or his judgements. He is a friend of mine and I would like to say at the outset that we have nothing....no personal animosity at all against Tom or aimed at his judgements. We

realize that he is put in the position of representing the medical community and we see his participation in this case as the medical community's participation and not his, personally. I would also like to point out that never....at no time during the publication of our articles did we reveal the identity of the individuals involved in this case, the mother or the infant. We have had the identities since early in the case, before we published. But at no time have we revealed those identities. That is important because I think part of the defense of not releasing information is that there was a pledge not to reveal the identity of the people involved. We have known their identities, and we have not, as a matter of news judgement, released the identity.

My statement is going to be very brief. In the exchange of written material between the Post and Tom Reese we have got into a lot of side issues, and we have brought up, on both sides I think, a lot of material that really is irrelevant to the central issue. I think that the Committee has only one determination to make, and that is whether this case properly falls within the definition of a 'public figure,' according to the definition, loosely defined definition on page 5 of the recently revised code. A lot of arguments are made why the Post should or shouldn't publish information, whether it was proper, whether it was ethical, but I don't see any of those being, really, a matter of substance before this panel. I think the only matter of substance is to determine whether this case falls within the definition of a 'public figure' in the code, and whether the information was properly or improperly withheld when we made inquiries. There is a side issue to that central issue, and that is one of the.....a debate, I guess, that is going on within the medical community, itself, now...and that is the propriety of doctors withholding information until that information is published in a medical journal. That has bearing on this case, directly, because apparently there is an agreement that the information would be released to a medical journal, but to no one else. And I understand that that is a raging controversy now within the medical community, itself...uh...whether this

is proper conduct or not. To speak to that issue, I'd like to call on Bill Symons and have him discuss that:

Symons: Thank you Chuck. I have brought a rather unweildy copy of the stories, because the computer and I don't get along very well. It is hard to follow, but if someone would like to have it for the record. I am the kind of guy that tends to freeze up and lose track of my thoughts in front of a group of more than three or four, so I have taken some notes, and I find that Chuck got ahead of me on several points. I do think the basic issue was pretty well covered in the grievance sent to Sherry on August 7th, and also in my response of September 28th. I too, even though Chuck has said it, I want to stress that my personal relationships with Tom have been and are good. He has always cooperative and helpful with the one exception where we've had a point of disagreement. I do understand that Tom had no choice in this instance except to support Dr. Clewell stand on not releasing any information to the media at this time. However, there is one point where Tom and I are....my memory of our first conversation and Tom's statement of his memory...are pretty sharply conflicting. My memory of our conversation, I think it was June 2nd....not June 4th....that you told me then that another inquiry had been made by another publication, which I believe was identified only as a non-Denver publication. I had a very clear impression on that day that that publication would have priority in use of any stories that were printed and that I would, as I said in my statement, I believe, felt I would be second in line in any case. It did, in fact, take me two or three weeks after that time to learn and verify that Tom's reference was to the New York Times, but aside from that I think we are into a basically philosophical difference which Chuck did allude to. I feel it all derives from the so-called Inglefinger Rule. Those of you in the medical profession are all aware, of course, of what the rule is. For others of you who aren't, if I can take about two minutes. Coincidentally, last September....on this September 30th, an Associated Press story came in out of Boston which, I think, very concisely summarizes

the background of the Inglefinger Rule. I'd like to read about four paragraphs of that:

"The editor of the New England Journal of Medicine, defending his refusal to print studies publicized elsewhere, says the controversial rule is good for the journal and good for medicine. The policy has been widely criticized by other editors, including those of the editors of the Journal's chief rival, the Journal of the American Medical Association. Under the Inglefinger Rule, named for its creator, former editor Franz Inglefinger, the journal refuses to publish medical studies if the results have been published elsewhere, even in newspaper stories. The New England Journal is widely regarded as the nation's most prestigious medical news forum. Medical reporters complain that the Inglefinger Rule makes researchers reluctant to discuss work before it is published, even if the chances are slim that it will be published in the N.E. Journal."

I will skip paragraphs in defense by the current editor. One paragraph I'd like to read. The editor was apparently responding to a sharp attack published last January in the J.A.M.A. Its editors called the policy unrealistic and elitist and said it is an attempted information monopoly. Because that summarizes my feeling so well I did want to read it. I will leave it here for anybody who might want to look at the portions I did not read.

In that regard I, since publication of the Post stories, have talked with responsible doctors in Denver and public relations personnel at hospitals here, many of whom believe that the story should have been published. In fact there are some who feel that the media, in general, were remiss in not having it earlier. As Chuck did, I do want to emphasize that none of our stories included the mother of the baby, and for that reason I think that we, in no way, have violated any of the assurances give by the doctors and the hospital that the mother's name would not be mentioned. I think that the basic question is simply whether the public has the right to know about the most important achievements in an institution like the medical center which is largely tax supported. I think tax support is a

very key point here. I think the public should know in a timely manner....not after months or longer of going through the N.E. Journal procedures. Actually, I'd say the grievance, itself, is a rather unfortunate spinoff of this basic philosophical difference, which I remind you again that the N.E. Journal and the AMA Journal are not in agreement. I do, also, think that the Post was only fulfilling its obligation to the public in reporting the surgery. Because I believe that, I of course, have to say that we should have been provided with full information from the beginning and, of course, extending to the condition reports, which did become the basis for the grievance. I think that's the end of my comment and time. In the following transcription, names have been abbreviated using the first letter of the last name of the speaker:

Green: The only other item I'd like to point out is in anticipation of the argument on the other side, I'd like to read from our article...two paragraphs. In his written remarks, Tom Reese points out that one reason for the hospital policy is to prevent the raising of false hopes within the community. He said in his letter 'what if the experiment failed and the child dies? Then, what about the raised hopes of the next family? I'd like to point out that in our initial story, which was quite long....it started on the front page but went inside....quite high in the front page of the story, so it wasn't buried...we say: 'It was clear they believe ('they' meaning the hospital officials who would not give us information) publication of any reports on the surgery before delivery of the baby could build false hopes among other parents.....hopes that could not be justified by the preliminary indications of success in the C.U. case. It was clear, also, they were concerned about ethical and social considerations which team members will examine in a paper expected to be published.' So, we made it quite clear in the story that we did publish that these were preliminary findings, and that certainly no person in our reading audience should take this report as the final word on this type of procedure. We recognized that false hopes could be raised and we tried to avoid that with the article, itself.

O'Haire: Any other comments?
(no comments)

O'Haire: Tom...your turn.

Reese: Well, I'm Tom Reese and I am Director of News Media Relations at the University of Colorado Health Sciences Center, and I guess all I really want to say...and that is to point out what I have written to you....and that is that my office is not an office that is designed to keep news from the public. I maintain that we have a very open policy. We're going to have an open policy as long as I'm there and I think that if you check with any news office in the city of Denver you would find that policy is still in effect. In fact, we have told them about things they didn't even know about until we called. Granted, some of that...and most of it is of a routine nature, but it's still there. We've also talked about the good and we've talked about the bad. And that's the way I work. And...we're in a situation here that I view with a clear conscience. My job is to relate the information and we have never said that we would never inform the public of what was going on. In fact, what we're saying, and have said from the outset, is as soon as we can talk about it, and know the full implications of what is involved...good or bad...if, for some reason this procedure does not work, we will explain why it didn't work...or try to. And if it does work, we'll tell that, but right now, as I'm talking to you this day, we do not know.

So what we have here, I guess I'd have to say in my view, is that we have a request for information. We're saying, and have said, 'yes, we will give this to you.' And, I'm guided, of course, by law, and I have had advice by legal counsel that had I broken two contracts involved in this (the mother signed an informed consent procedure before this could even be done in which she was assured of her privacy), I might add that after the first story came out, we got a number of calls, including some from the "That's Incredible" television program, the National Enquirer and The Star wanting to get in on this, and since then...even today, as a matter of fact, I've had calls from maybe 25-50 reporters from around the country. I told them the same story that I've told Bill, and that is that 'as soon as we can tell you

something, we will.' And...this morning, for example, I had a network reporter call me wanting to know about this...went over the, what I consider the special circumstances in the case, and explained that we're really not in a position to talk about it yet. This particular reporter is looking at a deadline, albeit, it is wavering a little bit, but agreed that I was right, and will wait until I call or if she gets down on her deadline real hard she'll call back.

I guess, based on all the reaction I've gotten...and sure, everybody'd like the story....it looks like a darned good story....uh..I think it will be, but that remains to be seen....and right now I don't think we've got a story. We've got a half a story...but everybody I've talked to has gone along with this and agreed that....yes, we'll wait..and...so in the area of good judgement I think I've exercised the best judgement that I can, under the guidelines that I was given by the law....and, I have to respect the patient-doctor relationship that those professionals who are working on this case are dealing with. I really can't ask them to go beyond where they feel they can go. I can ask and they can still say no, and I still can't give you an answer. So, based on that there's nothing I can talk about until we have everything squared away. My problem, I guess, is that I must be kind of thick and I'm looking at a case where we have a private patient who comes to the hospital....is referred to us by another doctor....on the grounds that this patient's privacy and condition will be protected. I think that's a very special circumstance. You've got to also remember that this is not just a hospital; this is a teaching and research center, as well, and they are looking at experimental procedures, procedures that are in many instances, not just this one, going to effect the lives of people and children to come. And so, I guess I would say this...we wouldn't even be here if we couldn't tell that patient that 'yes, we're going to take care of your privacy and your condition.' And that's what they did.

After the first article appeared, the mother became upset at some of the things that were in the article. And, prior to the delivery of the child by cesarean section, gave us written in-

structions that we were not to put out anything on her condition or the condition of her child, unless it was a medical necessity. She then went on to say that once the whole procedure could be evaluated, that yes, then we could talk about it. Again, the lawyer said, if you want to play with a lawsuit over the right of privacy, go ahead and release it, but I wouldn't. And so, I think my duty became rather clear-cut. I'm just not really anxious to get sued. I guess the question that's in my mind, and this is where I think this grievance committee might ask the Code of Cooperation Committee about this business of when does a person become a public person? It really bothers me; I haven't got an answer. Supreme Court doesn't really have an answer, either. It essentially says that 'we'll look at each case as it comes to us.' It has clear-cut answers on people who are public officials, people who are in accidents, people who are victims of crime, but, uh, here we have a patient, private patient, paying her own medical bills, coming to us...coming to specialists who can't be found or, assumably, can't be found anywhere else in the country, to try a procedure, and uh, somehow a draft of this report of the procedure was released. The principal parties of the team have all said they did not release it, did not authorize its release, and then based on the release of this report, almost in total, I understand (I didn't even see the report before it was published in the Denver Post), uh, we're put in the position of your saying that 'well, now we have a public person, and you have to tell us what we want to know.' I've got some trouble with that. I've got a lawyer on one side saying that I can't violate the privacy of a patient. On the other side, I have somebody saying that, under some guidelines, not law, but guidelines, this person is supposedly public and I have to release all kinds of information about it. It's not a very nice position to be in. I don't like it. It's just not my style, and I, frankly, am still in that position. I can't talk about this until we find out where we are, and I guess that's the main point we're after is.....I really feel that I have dealt with special circumstances. I feel I've used my best judgement,

and it seems to be backed up by reporters around the country I've talked to.

As to the Inglefinger Rule....that's been around a long time...I encountered that back in the fifties when I got into the science writing business.....and I'll be very frank.....I can understand Bill's position. I've been in the same position...probably still am. I don't believe that a publication ought to be...a journal publication...ought to be able to tie up information going out to the public. I don't think that's the case here; we just don't know! We don't know what we can tell the public yet because we haven't seen the results. Do we have a vegetable? Do we have a child that can perform? We haven't got any answers. We can say that 'Gee Whiz! We did a fantastic piece of surgery and inserted a spaghetti-like tube into the head of a child, in utero.' That's all we can say. That's like saying "Golly, we transplanted a heart, and the patient died." Or the old joke: the operation was a success, but the patient died. I have problems with that and so I guess I need some guidelines from the Code of Cooperation that I don't find in the Code, and maybe that's because I'm pretty thick, but I feel that we're on the side of the angels, and the Post feels its on the side of the angels, but I can tell you this right now: the minute we can talk about it, its going to be there for the public, and the public's right to know will be served.

O'Haire: Do you have anybody else from the Health Sciences Center?

Reese: No.

O'Haire: Why don't we take a minute or two...do you have any reaction to Tom's comments? No? O.K., the committee has ten minutes....for any questions or clarification:

Bosch: Do I understand you to say that, as a private patient, she or her family covered her medical bills?

Reese: That's my understanding that the patient....as you know, it's really not quite true to say that we're a public, tax-paid institution. About a third of it comes from the legislature through the general fund, a third comes from the faculty-practice fund, and the rest comes from research. The faculty-practice of course, covers practice of physi-

cians at the hospital. This woman was taken in as a private patient of these doctors for the express purpose of this experimental surgery. My understanding is that the procedures that were carried out were paid for by her insurance, or whatever. The doctors did receive, I believe, some assistance of a small grant through the research center we have there at the hospital for the actual preparation of the shunt device, itself. The thing to remember, though, is that even with that we have never said we are not going to tell the public. The public's right to know is still there, and we are going to do that.

Czupor: Tom, was this patient in any way considered to be a public figure before entering the hospital?

Reese: Not to my knowledge. She was a housewife and the special circumstance in her case was that....I don't know if you're familiar with this condition, the hydrocephalic condition, but it effects males....and she had delivered one male child earlier. The child subsequently died from this condition. She then delivered a female child and, then, during the course of this pregnancy it was discovered we had a similar condition. The doctors involved were known for their work, especially in utero blood transfusions, fetal transfusions, and it was referred to them.

Czupor: Were you able to determine the sex of this baby?

Reese: Was I?

Czupor: Was the Center?

Reese: Yes, it had been done through ultrasound.

Czupor: How did the New York Times story get out?

Reese: The way I got it is that someone who had been involved in some fashion with the actual implantation had gone to an ultrasound meeting back in that area, and said 'Hey...we did something really wonderful.' The reporter from the New York Times heard about it and he was involved in a piece that was an overview of fetal surgery and treatment of dysfunction. He called to see if it was true. The team here admitted that 'yes, we've done it,' and told him and he got excited and wanted to know more about it, and they said 'well, we don't know.' It turned out that the reporter said 'well, O.K., I agree with you: we

haven't got a story. I want to know about it when you do because I want to follow it up.' He told them at that time that he would probably mention it in his overview story, which he did. And there was about a paragraph mention in the New York Times. I think I told Bill it was on the 31st of May...I remember because it was on my birthday, which was actually the 26th.

West: What is the determining factor in, as you have stated, that when you can talk about it, you will....what is the determining factor there?

Reese: The child, as I understand it, will undergo a neurological examination, and the doctor here can probably bear me out, or tell me, if I misunderstand what happens in this kind of a case, the hydrocephalic condition is when fluid presses the brain up against the skull.

West: From inside?

Reese: From inside, yes, and completely kills the cells. (Reese, turning to Dr. Coleman at committee table...away from microphone, became difficult to understand) and would become demented by this, and there would be a disfigurement...right? So, the ultimate problem: will the child die? The other problems are what retardation might result? The control of their sight, speech, intellectual capabilities, are in the upper half of the brain, and the pressing out, destroying cells....nobody knows what kind of effect this can have. And, I think I mentioned, even inserting the shunt, they don't know whether that will do any damage or not. So, the purpose of the neurological exam is to try to determine, albeit at a very early stage, what kind of condition has resulted from this particular surgery. My guess is, and this is only a layman's guess, but my guess is that we won't know, totally, before a year or more in the child's natural development. We're not saying we're going to wait a year.

West: Has that child outlived his brother, who died earlier?

Reese: Yes, I think that child died within two weeks. This child is still alive.

Coleman: I have a question for Chuck (green). I understand the interest in the newspaper with providing the public information to

which it has a right, but what I am not sure of is what the urgency was in this situation. Now, some of motivation, I imagine, is that someone else is going to beat us and print it some other place. And naturally you want to be, especially in Denver, the primary publication.....but what was the hurry?

Green: There were several considerations on the rush to print, as it's been described in some of these documents, was not a major consideration, but it was one: first of all, we didn't just stumble across this report. We were told by members of medical community of a matter of some import and significance, and they felt it ought to be publicized....now!...not a year from now.

Coleman: That was their feeling of urgency about it?

Green: I can't answer that question. They just felt that it was something of....newsworthiness. 'They' were not necessarily physicians....'they' included other people.

Coleman: Do you have names of people who told you that?

Green: I can't get into this because of some confidentiality.

Symons: (inaudible.....) doctors included.

Green: Not secretaries or receptionists.

Coleman: By the same token, you can't reveal where the draft of the report of the procedure came from?

Green: The draft came from a medical person.....

Symons: I'd say....'a responsible source.'

Green: Let me point out something else that bears directly on the question: Tom said that the determination of the release of the information would come when these factors were determined: what degree of retardation would develop? what damage resulted from inserting the shunt? Listen to the letter written on July 28th...we received it, I believe on August 1st or July 30th....from John Cowey, Chancellor of the Health Sciences Center...and this is the reason he gave.....I'll read you the letter....this is his explanation of why we shouldn't publish a story: 'The feature article in the June 28, 1981, Sunday edition of the Denver Post

entitled 'Denver Surgery on Fetus' and its supplement, 'Fetus Surgery: Study in Pioneering Medical Skill,' has precipitated much disquietude at the University Hospital. The medical personnel involved were shocked, to say the least, when a supposedly top-secret and confidential operation appeared in bold print on the front page of your newspaper. (Parenthetically, we didn't use any bolder print on that story than on the rest of the newspaper that day). The surgical procedure noted in the article was taken from a confidential report which the Denver Post illegally obtained (I don't know of any laws governing us). The newspaper had actual knowledge of 1) the confidential nature of the report and, 2) that the report was being prepared for publication in the New England Journal of Medicine, whereas the newspaper was expressly notified not to publish any portion of this report, and willfully did so publish. Such action constitutes a private copyright infringement of an unpublished work (I am not aware that this unpublished work was copyrighted at the time). The Denver Post is informed to cease and desist from any further reference to both the article and the confidential report in any manner or form until the University Hospital or its medical personnel authorizes the release of such information. We regret that the Denver Post did not feel the necessity to protect the confidentiality of this report. It is our hope to maintain good public relations (cough)...the Denver Post. However, we hope that in the future the (unintelligible) can be more responsible in a professional manner.'

This letter indicates to us the only consideration of the release of information is the article's publication in the New England Journal of Medicine. There is no reference here...not even a hint of concern over the condition of the child following the operation....none of that is mentioned. It is apparently only a matter of concern whether the New England Journal of Medicine publishes the article.

O'Haire: Any other questions?

Green: Which I would remind you, is a matter of controversy within the medical profession, itself.

O'Haire: May we have a copy of that letter and the New York Times article?

Green: I'll provide you a copy of the letter...I can't provide the New York Times Article.

Symons: I think I can.....I found one.

Czupor: What Chuck Green's brought up is an interesting point....and Tom, if you can answer this....from the accounts given and what Chuck has pointed out....was the overriding concern for the patient, or for publication in the New England Journal?

Reese: Let me answer that...but let me first make a clarification....I told you the first child....first male child died in two weeks. That was an error....the first male child died at four months with serious mental problems. The last male child is now two months old, so we're still waiting to see what the effect is going to be. I apologize for that...I was under the impression that it was two weeks. I have dealt with the principals in this case since the Times reporter called, and I will tell you this: I've never seen men more dedicated to the patient or patients than I've seen in the doctors that I've dealt with. If I ever had any reason to be cynical, these men have changed my mind a great deal. Their whole approach to this thing has been the best outlook for their patient to this extent: now, here I am, a spokesman for them...for the hospital's medical center....they wouldn't even tell me her name. I didn't even see the paper until after it was published in the Denver Post. Gentlemen, they just flat took care of their patient, and I would expect as much if I were under a doctor's care.

This is one of those things when you have a breakdown like this, I guess....and the Chancellor was out of town when all this happened. President of the University read the article, understood there was some problem; understood that the basis for the article was (unintelligible) therefore, he considered it to be unauthorized publishing. He directed the lawyers to write a response...he didn't direct the Public Information Director to write a response...he directed the lawyers. The lawyers got going, they did their response; they sent it

down....Chancellor came in and saw this and....he put his name on it. He probably shouldn't have, but he did. And that was all. It's the kind of thing that happens when you have an institution like ours that has a number of campuses and many, many employees and you get caught in a situation like this. I think the letter....we all would regret having been sent..and that's what happens when something like that gets going. (unintelligible conversation with some member of committee.....) Yes...John Cowee...and, so we're trying to maintain an open door on something like, and then you get reaction...gut reaction come across....that's what happened in this letter.

Green: On this direct point...the letter was one of two communications along the same line received....Gay, you can tell about the second:

Cook: I, initially, was working as an editor with Bill (Symons) on this story, and that time, for a short period of time, Carl Miller, our Executive City Editor, worked with Bill on this story...on the story, I'm talking about the one on June 28th. That was a Sunday story. The Friday before we published that story, it became known at that point because of inquiries that we had made as to the makeup of the team performing the surgery, that the head of the team, Dr. Clewell was quite angry and upset that we were going to publish the story. He called and talked to Carl Miller saying that if we published the story, it would establish pre-publication with the New England Journal of Medicine. It was during this conversation with Mr. Miller that it was not the condition of the patient...but rather, publication by the Denver Post of this story was going to destroy the chance of publishing an article in the New England Journal of Medicine. That, actually, was the first communication. The second communication was the letter from Chancellor Cowee.

Reese: Meaning no offense to the Doctor, he is only one of five doctors on that team. I think you also have to realize that the team has worked very, very hard in taking care of the child who is going to have to be delivered by cesarean...and done with

(unintelligible), and one that requires the utmost skill. And if that isn't a stress situation....and the other point I would make is that you've also got to remember that this is an experiment...this isn't an accepted protocol in any hospital in the way of an experiment. The patient admitted herself to have an experiment done on herself. Now, knowing this, and I think I mentioned in my letter to you (Grievance Committee), there is no technology to be had....and the only way you can communicate with your colleagues is through the New England Medical Journal and if you can't communicate with your colleagues, how are they going to be able to question what you're doing? The way the process works is that the report is sent to the Journal, which is read by doctors in the field, and they raise questions and they raise objections

(NOTE: There were some other conversations between committee and parties, but these were minor points of clarification.)

Unidentifiable Committee member to Bill Symons: What has been your previous relationship with the UCHSC?

Symons: In my experience, excellent, with a small modification, but my answer is still excellent, but I do feel that through the policies set down, many exciting things are occurring up there, that are of public interest, in fact which Tom pointed out in his letter to the Committee. I would like to have us consider here today whether we should not, one more time, give more emphasis to the public interest, the public stake into some of these things that presumably are going on, are important but, indeed, may not come out for months or years, except in this case almost by accident or, at least, intervention by those who felt it should come out. (Unintelligible) superficially, certainly, when I ask Tom for any help he's always cooperative, our relationship is excellent.

Green: I would second that, only to say that our relationship with the Center has probably improved while Tom has been there.

Symons: Yes.

O'Haire: Any other questions from the Committee? All right. We'd like

to take no more than ten minutes, questions by the Post about

Symons: Questions by the Post to....?

O'Haire: Right...to the Health Sciences Center.

Green: Let me ask Tom...is this pledge of confidentiality still in effect between the Science Center and doctors, or whoever is a party to the agreement, and the patient?

Reese: Yes, it is.

Green: How is it that the doctors, then, can go to a public meeting of doctors, and properly observed by the New York Times reporter, and discuss details of the case which you can't release to us?

Reese: That was not a doctor.

Green: Who was it? Was it a representative of the Science Center?

Reese: It is my understanding that it was a technician that was there.

Green: A representative of the Science Center?

Reese: I don't know that they were representing us at all.

Green: An employee of the Science Center?

Reese: I would assume so, but I can't even tell you that.

Green: So that could have been a violation of the uh...?

Reese: Certainly could.

Green: Then how is it that all of the details that are discussed in your letter and the meeting today.....things like: the family has chosen not to go the abortion route; she had a cesarean delivery; various details of the family situation; the fact the mother was disturbed; the ultrasonic examination; she admitted herself; she has paid her own bills....all of those details are fine....but you can't answer any of our questions?

Reese: All those details were in your story...many of them.

Green: And you've just confirmed them. Is that a violation of your agreement?

Reese: It probably is, but I assume we're talking here and laying it on the line.

Green: We also understand from extremely reliable sources that this case been discussed rather openly at cocktail parties and other.....situations by medical personnel, and that seems to me to be a violation of the agreement.

Reese: No, I saw that comment

and I asked members of the team if they had done this, and I was told that, at least, the primary members of the team had never discussed this at cocktail parties, and if it were discussed at cocktail parties it would probably have been done through hearsay. I know I haven't discussed it at cocktail parties....

Green: No! I know...You're not the one...

Reese:and I can't talk for anybody else's ethics. I'm stuck with mine.

Green: I just point out, it seems to me, that a lot of details of this case have been discussed in many forms. The objection seems to be that the Post published them before the doctors had a chance to publish them in the Journal, and there seems to be an overriding concern about the patient's privacy, and I would again point out that we did not publish the identity of the patient, although we did have access to it. Also, I'm not aware of any inaccuracies in our published report. To me, something that you've alluded to today...you said that the Post seems to be alone in its opinion that this is newsworthy and ought to be published now. Are you prepared to assure me that if the New York Times, Associated Press, or CBS, or NBC, or Today Show, or anyone else that made inquiries to you, if they were to be provided a copy of this report, can you assure me that they wouldn't publish it? I mean, so far, I don't think they have any facts to publish...because you haven't given them to them. But if they were to be provided a copy of the report, do you think they would still withhold publication?

Reese: I'll tell you what the NBC Science Editor told me: He was appalled that an unpublished draft of a paper was used as the basis of a story.

Green: Had he seen the story?

Reese: I don't know whether he had or not. I assume he had because it had run on the wire. And I can only say...I can't tell you what their thinking is beyond the fact that their response to me, when I've talked to the media here, when I've talked to all those people that are listed in the letter and the latest inquiry I got this morning, when I've explained what we view as special circumstances, uh...they said 'O.K., just let us know when you're ready to go.' That's all I

can tell you.

Green: They...they don't, as far as you know, they don't have any real solid details to go with?

Reese: I have no idea.

Green: You would acknowledge that there's no provision in the code that exempts private patients from becoming public figures, just because they pay their own bills, or at least part of their own bills?

Reese: Well, my question, Chuck, is that that part of this particular code, which is a guideline, is pretty ambiguous, and that's really a point, to me, that we ought to probably be looking at to avoid problems like this in the future. I think this is where our pr....why we're here, frankly, is that I feel that I'm following the guidelines. You feel that I am not. I'm saying that in my best judgement I'm following what I perceive is the guidelines. And you're saying in your judgement you perceive what are the guidelines. The guidelines tell us what we have to do, so to speak, or the guide is this is what you should do. On the other side of it, there's very little guide as to what the media has to do. A section in there that says...I forget what it is, now, but it deals with we really have a right to...or need to put out the information in a timely fashion, and the like. But it doesn't d....on that side of the fence it doesn't say, you know, what is our responsibility to the community there, you know....are we going to raise somebody's hopes? For example, and let me give you a really personal example, and it is not near the significance that this is....but I have a child...a son who, in his teen-age years became a victim of epilepsy. I'll tell you...I'm sure there are other instances, but I am sure that for this father...there's nothing more tearing to me than to watch my son go through a grand mal seizure, and he'd gone through several of them, one of which in a fall he cut his eye open...was bleeding. I can only perform, you know, what kind of emergency procedures you could perform on the child. At that particular time we were experimenting with a series of drugs used to control grand mal and petit mal seizures. The story....I just thought of this this morning, this story appeared in the next morning's paper about a drug that I can't even pronounce the

name of...it was developed in France....(unrecognizable name). The gist of the story was that this is the greatest thing since sliced bread for epilepsy victims....take this and no more grand mal seizures. I thought, my God, that's great! I talked to the neurologist and he said, 'well, yeah, but we can't give it to you.' Here, I thought I had a chance to take some pain out of my son, and he had to tell me that he couldn't give it to me...the reason, of course, was that the Federal Drug Administration hadn't okayed the drug for use in this country, yet. He actually had a couple of...he had permission to use it on two patients....he got this from the FDA...or whoever it is, and he had to use it on his worst cases. I'll tell you my hopes were up that I could prevent some pain and I wouldn't have to see this thing again....and I had to go back and say no, I can't do anything for you now. It has since been okayed and he now has it and his grand mal seizures are under control. But that's just how I felt...just totally helpless in dealing with this: I had a hope and I had it dashed real quick, and I can just imagine in my own mind what happens to a parent who's gone through what this patient has gone through.

Green: My mother died of abdominal cancer two years ago, and because of newspaper articles I had read during her long and agonizing sickness I was able to ask some questions that were illuminating and I was able to get information from the doctors that otherwise I would not have been given, just because they weren't volunteered, so there are two sides.

O'Haire: Any other questions from the Post?

Symons: I have some points, not questions, for them....it'd be best if I hold them for the final summary.

O'Haire: Tom, do you have questions for The Post?

Reese: No.

O'Haire: Any questions by the committee that we need to present at this time?

Coleman: If the Post did publish this, I'm not clear exactly what still is the objection in their...in your lack of communication from the Sciences Center. I mean, you were refused the information so you have obtained it through some mysterious

sources and, so now what is...you still have a complaint that you're still not being informed?

Symons: May I respond to that? The basic reason for the grievance being filed is: specifically, after we became aware that the baby had been born...delivered, when I repeatedly called and asked for, only, a condition report on the baby that we knew was there, I was told not only by Tom but by others, that they would not give a condition report. That's the point of the grievance, but as I see it the background issues are far broader and far more important. The reason why Tom could not give even a condition report would all tie in with the ...back to the Inglefinger Rule. They all tie so closely that beyond the grievance there is a question of 'does not the public have the right to timely information regarding anything so important as this that happens in our own back yard?'

Green: Let me respond to that also by saying that the complaint was filed more than two months ago....

Coleman: But this was filed after the publication of the article.

Green: Just a few days after, but at that point we were still, and continue to be, vitally interested in this case, and are still asking for condition information, are still trying to get information from the Science Center and we will continue to do that for many months to come:

Cook: I think it's important to point out that we understand completely that it will take some time for the doctors to perform the neurological tests that Mr. Reese talked about earlier; that it is impossible, probably, for the doctors, at this point, to tell us, definitively, whether the procedure was a success. But the fact is that the child has been born; the child continues to live, we assume, and on that basis the child, irregardless of the success of the shunt procedure, is in satisfactory condition, or good condition, or critical condition, and that's what we're after at this point. We're not asking the doctors, we're not asking Mr. Reese, we're not asking the Health Sciences Center to tell us, definitively, was this procedure a success, but given that the child is still alive at this point, is the child's condition good...is it bad?

Green: And, also, we would like to

go with official information that's been confirmed by the Science Center rather than information we pick up from subterranean sources, however reliable we may consider them to be. It's always our preference to go with confirmed and verified information, short of that, sometimes, we have to publish anyway, but that's not our preference.

Coleman: Perhaps, one could picture this as a contest between the public's right to know and the right to privacy. I know that you've emphasized the Inglefinger fright of doctors, but, how do you feel about the probable fact that, even though you didn't disclose the name of the patient, you certainly disclosed everything else, which was something the patient had really not bargained for, according to Tom Reese. And yet, this splash on the front page really destroyed that confidentiality, if not the confidence of the patient in the Medical Center?

Green: Of course, I guess one of our concerns here is: is the medical center giving these pledges of confidentiality in violation of the code? If so, we should resolve that conflict. I don't know, because I wasn't privy to the conversations, but I wonder whether the attorney, and I've worked with many attorneys during my career, whether attorneys even consider the alternative of discussing with this patient, can we discuss your case but conceal your identity? That, as far as I'm concerned, would be quite acceptable under the code, and may well have been acceptable to the patient. I don't know, but I can certainly foresee that that might be the situation.

Coleman: It's hard to know what the patient had in mind when they got the agreement that it wouldn't be publicized.

Green: But that's something the medical community has to wrestle with. Are we violating the code by promising people that their names or their situations will ever be publicized? First of all, I don't see how they can promise that, because they don't control what we or anyone else publishes, although they order us to cease and desist. I think that maybe doctors and lawyers need to become better acquainted with what the medical community has agreed with in this

code. I'm not sure they're as well aware of it as they ought to be.

Coleman: Then it's your position that the fetus or the mother became famous or public person as a result of this procedure?

Green: That's our interpretation. We don't see much difference between this case and a transplant case, which is the only thing that is cited specifically in the code. We're given information on transplant cases before determination of survival is made. A transplant patient may die three or four months later, but that doesn't hold up the release of information. There seem to be some standards being applied to this case that are not being applied in other cases, and we're concerned about that discrepancy.

O'Haire: Any other questions by the committee?

Czupor: Tom, if I could ask another question...it would be interesting: what is the Health Science Center's policy on transplant operations or other experimental operations of this nature?

Reese: It's basically this: the statements released by the hospital are governed, of course, by the public figure position. It is also governed by the doctor determining whether the release of the information will effect the well-being of his client. So, essentially, I might have a transplant patient, and I might point out that this is not an experimental procedure. It hasn't been for many years. It is almost a routine (the transplant surgery) as opposed to an experimental surgery. So, if a patient admits himself, and we've had these cases where a patient is at home and talks about 'I'm going down to CGH and get my transplant.' He shows up at the hospital and the newspaper calls and says 'How's Joe Doaks doing?' I'll try to get hold of his attending physician and explain to him that, under this code, the person himself made him a public person, and therefore I have to, at least, give a condition report. I've really not had any problem getting that kind of report. We don't go rushing out and say 'Hey, we've done another transplant' or go out and say 'we've taken out another set of tonsils' or 'we've delivered our 232nd baby this month.' We respond to that whenever we can.

Czupor: So you handle on an in-

dividual basis?

Reese: Oh, yeah.

Symons: This will be, in part, repetitious. I think I've made my basic points about the public's right to know and the split in philosophy between news and, at least, some portion of the medical community. I would like to respond briefly to a couple of points that Tom made that only illustrate this difference: Tom mentioned his contact with news media representatives. I, too, have many contacts from Newsweek, to People magazine, a paper in South Africa, etc. One quote comes to mind from a Newsweek correspondent in San Francisco who, using his term, feels that the New England Journal has a full-nelson on the medical profession because of this Inglefinger Rule. Tom also did make reference to the Journal being a means for the physicians to communicate among their peers. Again, that is separate from AMA Journal policy. But I did feel, and I want to emphasize, that I think that's what makes the Inglefinger Rule so insidious. Were it not for that rule, there could be pre-publication, as ours was. The doctors could go ahead and have the communication among themselves, on the basis of the Journal reports, but not, at the same time, depriving the public of timely information on developments that are important. Again, I have to note that the Post was not the first disclosure. The New York Times story on May 31st or 26th was, indeed, disclosure, and about all that would be of interest in New York. I do submit that the Denver Post's interest is far greater than the New York Times in something that happened at the CU Medical Center.

Green: First, I'd like to point out that the Code does not have any provision that provides for a poll of news media to determine, by a majority vote, whether something should be published or is newsworthy.

I submit that, although I am not going to do this, I submit that if Tom would give me a list of people who have told him they are not going to publish something, if I would mail a copy of this Journal article to them, they would probably publish the information. I think the reason they are not publishing now is because they don't have a reliable source

from which to work. I would also point out that from my contact with doctors in a couple of family situations, my mother being one, my father another, that many physicians don't put much credence in journal reports, let alone newspaper articles. I had one doctor in Denver tell me that research frequently is published in journal reports and then a complete change is reported a year or two later, and that, really, nothing in the field of medicine, especially cancer research, is, at this point, very definitive.

I would like to re-focus the entire question to the one point of contention, and that is: should this case have fallen into the category of public figure? I would also say that the strongest argument that this is a case of public interest and that it should be considered a public figure case is that, apparently, the medical community itself determined that it should be submitted to an international journal for distribution, worldwide. The only contention is, not, was it a matter of a public figure, but who should determine that: the New York (England) Journal of Medicine, or some newspaper in Denver? We came to the same conclusion that the doctors on the team came to, and that is that it was of significant interest in the community, and should be distributed. We just decided to distribute it before they did.

I would point out, again, that there have been no inaccuracies brought to our attention in the article. We think it was in proper context. We pointed out in several ways that nothing conclusive could be drawn from the procedure, at the point that we published, and we did not reveal the identity or invade the privacy of the patient involved. I think the real problem here is: did the Health Sciences Center go beyond what it should have gone beyond, according to the Code, and promise the patient something it couldn't deliver? We'll waive the rest of our time.

O'Haire: Tom, do you have anything?

Reese: Well, I think we have, from my point of view, or our point of view, or whatever you want to call it, we have to look at two things, or at least a couple of things here: 1) the patient would not have even ar-

rived out there, would not even have been referred to us had not her privacy, the guardianship of her privacy been promised. She went into the initial operation signing a document that provided that the record of the procedure and her participation in it would be kept in the strictest of confidence. She also signed a document prior to the initial....the document that she signed prior to the initial surgery stated that: while the results may ultimately be presented in a professional journal, neither the patient's name nor any other specific identifying information will be revealed. After the first release of the story, she directed in writing that no information regarding her unborn infant be released to anyone except as a medical necessity. And she directed that until such time that her son's condition could be discussed with certainty, no public disclosure of his condition be made. Acting under advice from counsel, I don't think I could do anything more than answer...respond the way I had to answer, which was that I could not discuss it. The problem of peer review, publication, we're not going to solve here. It's been going on for 20 years or more. There's no way we can solve it. That's going to have to be up to the scientists and the medical community and, granted, it is a topic of discussion. I think we do have a special circumstance here. We're not talking about tonsilectomies or transplants. We're talking about experimental surgery that's designed to further medical knowledge, and that medical knowledge has to be reviewed by other doctors. The other thing that comes up is that we talk about violation of code; well, that term 'violation' bothers me, because we are looking at the preamble of the Code, and that says 'guidelines,' and that we should be using common sense, and we should be using good judgement, and that we should try to get along. I agree with all that. I frankly think I have, given those guidelines. If I have misconstrued them, then maybe the Committee would do a favor for an old fella like me and sort of spell them out, because, I think, I have followed the dictates of the guidelines. The other thing here, the problem of a public figure, and I guess I have to agree with Chuck to

this extent that: yeah, when you have a public figure you have to respond to it, but the problem is: here, we have a person who has done everything she possibly could to ensure her privacy and that she did not become a public figure, and yet, through some fashion, her public figure was created by a particular medium. And then we're told that because we created this public figure, that we have to provide supporting data, after that. That's sort of a problem.

We didn't do anything to create that public figure, and my office didn't do anything to create that public figure, and so the person was not involved in a condition that, whereby, she had to deliver her baby on the street; she wasn't involved in an accident; she wasn't a victim of a crime, and she certainly was not a public figure as we know them: a mayor, a city councilman, or what have you. She didn't go out of her way prior to coming here, and say 'Hey! I'm going to CGH and have an experimental operation.' So, the public figure was created, all right, I guess you'd have to acknowledge, against her will, and I have to say that maybe we ought to look at that, as a committee.

O'Haire: Chuck, you have a couple of minutes to respond.

Green: First, the Post did not decide, unilaterally, that this case should be publicized. It was brought to our attention...I emphasize that...by medical personnel. We did not approach them...they approached us. Secondly, Tom says that the patient would not have been referred to CHG without a pledge of confidentiality, although he says in his letter that that pledge was given the day before the surgery. I assume that more than 24 hours was given before this team went into the operating room. I suspect that the referral was made more than 24 hours before the surgery, which is apparently when the first pledge was signed. Secondly, or thirdly, he said that the second agreement of confidentiality was signed after first publication of the information, and I presume, in that case, that he is referring to the New York Times article, since that was the first instance of publication.

Symons: I would add one very brief comment, if I may. I feel strong-

ly that the Denver Post did not make her a public figure. I think the fact of this innovative surgery is what made her a public figure, and we became only a party to publicizing that surgery.

Green: I'd like to take two minutes to discuss, in our profession, the concept of involuntary public figure...is that appropriate? There's a fellow named Oliver Sipple who attended a rally in San Francisco at which President Ford was speaking, and Oliver Sipple was standing next to a woman who raised a gun and started to fire at the President. Oliver Sipple knocked the gun out of the would-be assassin's hand. At that point, Oliver Sipple became a public figure, involuntarily, but a public figure. Many articles were written about Oliver Sipple, his life, who he was, why he did it, what it felt like to save a President's life. That wasn't a conscious decision by Oliver Sipple; it was a reaction, and he did not stop to think about the consequences; he just did it. That is what this provision in this Code addresses; an involuntary public figure; someone who becomes a public figure because of circumstances out of their control. I

think that's the situation we're speaking of here. I think that one result of this whole discussion might be a greater awareness and, maybe, some safeguards within the medical profession to advise people of this involuntary public figure consequence, although they may not want to become a public figure, that may be out of their control and out of the physician's control.

O'Haire: We will now recess, but before we do that I want to thank all of the parties involved for the very professional manner you've handled this hearing. Also, I want to thank the Committee for the questions, which I think are very pertinent to the subject at hand. As has been stated in the memo from Sherry Hartman, within three days we will give you the results of our deliberations. We are now in recess.

Hartman: I think the point needs to be made that when the grievance policy was adopted (by the Code of Cooperation Committee) it was stipulated that the results would be publicly released, and the decision by this committee will be publishable; it will be mailed to the news media.

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Results of Grievance Hearing Between Denver Post and University of Colorado Health Sciences Center, October 7, 1981

**Remarks and Decisions by
Robert E. O'Haire
Director of Development/Community
Relations, Mercy Medical Center**

"From the information presented - my conclusions are as follows:

The primary concern of the physicians involved was they did not want the story to break in a local paper and ruin their chances of having it published in the New England Journal of Medicine. The Post did not illegally obtain the report on the surgical procedure. When the information was given to them they contacted the Health Sciences Center and told them of their intent to publish the story. The Post followed the Code's confidentiality guidelines not to disclose the name, address or occupation. Only the patient and those in whom she confided would know her identity from the story. I feel that the Health Sciences Center was negligent in presenting adequate documentation on the patient's signed request for privacy. From information presented, the disclosure did not affect her medical condition or recovery.

The Post repeatedly stated they had no intention of releasing names; their only request for information was in regard to the current condition of the child.

My finding on the grievance is in favor of the Denver Post."

Findings and Decision by Meindert Bosch.

"I feel that the primary issue in this case is patient rights and matters of privacy and confidentiality. Publication in the New England Journal of Medicine as well as releases to other news media is important and possibly somewhat complex, which contributes to making a difficult decision but, in my opinion, patient rights and confidentiality are paramount. This continues to be the primary responsibility of the Health Sciences Center to the patient in this case.

The lack of a good definition of confidentiality and also what constitutes a public figure did not enhance the consideration of the matter. With the maze of information surrounding this case in terms of what is proper, I feel the benefit of the doubt must go to the patient and actions (or inactions) taken by

the Health Sciences Center to protect the patient. The obligation by the Health Sciences Center to the patient is also paramount.

Finding: In favor of the University of Colorado Health Sciences Center."

Findings and Decision by Jim West

"The focal point of the question should be, 'Is the event a public event or is the person a public person?' And, the promise of confidentiality made to the patient; was it made in good faith in accordance with the guidelines of the Code of Cooperation? I got the feeling that the confidentiality promise was made hastily to insure publication in the New England Journal of Medicine.

I endorse the responsibility for privacy, and feel that the identification of the patient was not violated by the Denver Post articles, since her name was never revealed, even though the Post had possession of her identification.

The surgical procedure was of such value that I feel it was definitely news and should have been reported in a timely fashion.

Finding: In favor of the Denver Post."

Findings and Decision by Thomas H. Coleman, MD

"The Denver Post editors were unnecessarily hasty in publishing a story over the objections of the HSC. That publication destroyed two important realities. One was the promise made by the doctors to a private patient that her surgery would be a private and confidential matter without publicity. Only on that condition did she agree to the procedure. The Post article destroyed her privacy and the agreement. The fact that her name was not used is not entirely pertinent. On the front page of an interstate Sunday newspaper, anonymity is not the same as privacy.

The second reality was the effect of this premature publication on the work of the doctors under the so-called "Inglefinger Rule" of the New England Journal of Medicine. Those editors will not publish a medical paper if it has previously appeared in the press or some other journal. Even though the rule is censorious or at least snooty, the fact is that the Post publication

probably assured that the HSC work will not be accepted by the New England Journal. This means a potential loss of prestige and recognition for the doctors, the HSC, and the State of Colorado.

Testimony indicated that the HSC in refusing information to the Post was trying only to live up to its promise to the patient and to protect the professionalism of its scientific work.

The Post editors invoke the 'public's right to know' to justify the publication. The public's right to know about this particular procedure was not urgent and was secondary to the patient's right to privacy and the doctor's right to professional prestige. I can understand that the sense of urgency at the Post might have come from a fear that another newspaper would publish the story first.

Mr. Chuck Green stated that the sole issue was whether the patient was a 'public or famous person' within the guidelines of the Code, by virtue of her unique surgery. The guidelines of the Code certainly are vague and could be improved upon, but the question of public or famous person is not the sole issue in this case.

Consequently, I do not believe the Denver Post has a legitimate grievance against the HSC."

Findings and Decisions: Z. James Czupor

"My personal opinion is that a patient's right to privacy supercedes the public's right to know and every effort should be made to preserve a patient's privacy. However, in this case, it appears that the UCHSC's medical team responsible for this patient was negligent in its promise to protect the patient's wishes that this procedure and her admission be kept in strictest confidence.

According to a memo addressed to the Grievance Committee, 'On April 29, 1981, the day before the initial surgery was performed, she signed an informed consent document that provided the record of this procedure and your (the patient's) participation will be kept in strictest confidence.

'While the results may ultimately be presented in a professional journal, neither your (patient's) name nor any other specific identifying information will be revealed,' the informed consent contract stated.

While testimony does not fully develop the following argument, it does appear that the

UCHSH's overriding concern was to protect the publication rights of this procedure until it could be published in the New England Journal of Medicine. If the article were subsequently published it would protect the patient's identity.

According to the Denver Post, a 'member of the medical community' leaked a draft of the report about the surgical procedure to the Denver Post. In my opinion, the Post acted responsibly in trying to obtain information through proper and official channels. The Post never printed the mother's name or any other identifying information even though that information was in their possession.

According to the Public Information Guidelines for Colorado Hospitals, Physicians, and News Media, developed by the Colorado Code of Cooperation Committee (rev. 1980), there are two categories of patients about which news can be released: 1) cases not recorded publicly, but thought to be in the general interest; and 2) cases of public record.

This particular incident is not a case of public record because it was not reportable to public authorities. In my opinion, because this surgical procedure was experimental in nature and had never been tried it falls into the first category '...thought to be in the general interest.' Therefore, the Denver Post acted in good judgement to publish information in the general interest and did so while protecting the patient's privacy. Furthermore, it should be noted in the record that the News Media Relations Office at UCHSC acted properly in its function to preserve this patient's privacy. Unfortunately, the News Media Relations Office was brought into this situation too late to counsel the medical team and administration about the potential news value of this procedure.

My finding: in favor of the Denver Post."

THE HONEYMOON IS OVER:

DR. JAMES SAMMONS

James Sammons, MD, Executive Vice President of the American Medical Association, told those attending the Forum for Medical Affairs program in Las Vegas December 6 that "1981 nation-wide facts clearly indicate that the honeymoon is over for the physician-owned companies writing medical liability insurance and the long tail on claims has arrived."

Although the frequency and severity of claims are increasing at an alarming rate, Dr. Sammons urged the continued support of physician-owned companies, because "they will be there when you need them." Dr. Sammons said that 45% of the national market is covered by physician-owned companies, and the American Medical Association Insurance Company is providing reinsurance for 45,000 physicians in the U.S. today.

Brad Cohn, MD, President of the California Medical Association, stated that California is experiencing a repeat of the 1974-75 crisis and doesn't see it changing. He blames the trend on the liberal courts in California, higher limits of claims, and higher costs for medical liability insurance. In talking about the liberal court systems, Dr. Cohn cites a recent court case in which it was decided that a physician must explain all risks if the patient refuses to submit to tests and then must be able to prove that he explained those risks to the patient if a claim results.

Arthur Mannix, MD, President of the Medical Liability Insurance Company, echoed the remarks of Dr. Cohn by stating that New York has been in a continuing crisis since 1973 with no relief in sight. One of the problems he sees with the increasing cost of medical liability insurance is that physicians can no longer pass the cost on to the patient. "We are looking at a fixed fee market whether we like it or not," he said.

The story from Indiana and New Jersey was much brighter. Gilbert M. Wilhelmus, MD, past president of the Indiana State Medical Association and a member of Indiana's Legislative Medical Malpractice Study Committee, stated that the number of claims being filed in Indiana today are the same as they were 2 1/2 years ago. He said the premiums for medical liability insurance has been stable since the passage of the Patient's Compensation Act in 1975, and there is no problem obtaining coverage.

Bernard H. Genest, Vice President, Claims Administration of the New Jersey State Medical Underwriters, Inc., said that there is no evidence

that there has been an increase in severity in New Jersey in the past five years. He felt that this was partially attributable to the short time it takes to close a claim in New Jersey---9.6 months---as opposed to the national average of 37 to 46 months. Mr. Genest stated the interest on reserves is not keeping up with medical liability inflation which is running at 30%, and this could create a problem for physician-owned companies in the future if management doesn't take action now.

In talking about the viability of physician-owned companies, Vernon B. Astler, MD, Chairman of the Board of the Florida Physicians Insurance Reciprocal, pointed out the need for loss control programs. He said that the Florida company held six loss control seminars in 1980 which were attended by 600 of their policyholders. The benefits derived from those seminars have been: less claims filed against those physicians who attended, and those physicians who attended, but have not been sued, have been far more defensible than those physicians who haven't attended. They increased the number of seminars to 37 in 1981 and have now reached more than 7,000 of their insured. Two of these seminars were video taped and will be made available to other states upon request.

In looking at some of the facts gathered through risk management, William D. Robertson, MD, Chairman, Risk Management Committee for the Washington State Medical Society, said that he believes you can improve the quality of medical care, reduce the risk to patient and physician, and control cost of premium and settlement if the program is set up properly. He feels that such a committee needs to look at the trends in malpractice claims--whether preventable--and the process for early detection and avoidance.

Dr. Robertson said that their records show that where adequate records are kept by a physician there is no payout in 64.5% of the claims. However, when inadequate records are kept, 61.4% result in paid claims. The same is true for reporting a suspected claim. For a suspected claim reported in less than a year, the mean cost for settling that claim is \$21,000. If it is not reported until three years or more, the cost for settling that same claim is \$65,00. In claims closed prior to 1980, informed consent was a problem in 21% of the claims. The claims opened in 1980-81 show informed consent has become a problem in 31% of the claims, Dr. Robertson stated. This is something we can control, he said.

(The Forum for Medical Affairs is composed of presidents, presidents-elect, editors of state medical association journals, executive directors of state medical associations, and representatives of AMA-recognized medical specialty societies.)

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WITNESSETH

WHEREAS, The Member has made application for membership in the trust and has been accepted as a member thereof, and desires to obtain the privileges of professional liability protection which the Trust will provide to its members.

NOW, THEREFORE, and in consideration of the mutual promises herein contained, it is agreed as follows:

1. The Member confirms that he/she has been advised of the conditions of membership in the Colorado Medical Society Professional Liability Trust as provided in the Trust Agreement, and agrees to abide by all terms and conditions thereof.

2. The Member has paid the sum of \$100 hereby receipted for, which sum shall apply upon his first year's premium under this plan, and agrees to pay the balance of the premium as billed.

3. Coverage shall be in accordance with the Professional Liability Policy to be issued by the Hartford Insurance Company, which will include the basic coverage to be provided by this Trust.

4. The Member agrees that the Trustees shall have the right to terminate his/her membership and all rights and privileges in the Trust, as provided in article VIII of the Trust Agreement, if the Member shall be guilty of any one or more of the following:

a. Failure to follow the provisions of the Trust Agreement, this Participation Agreement, or the Coverage Agreement.

b. Failure to follow the risk management or loss control rules and regulations established by the Trustees, Notice of which shall be furnished to the Member.

c. Breach of any of those qualifications for membership set forth in the Trust Agreement.

d. Failure to give prompt notice to the Trustees of one or more incidents or claims.

e. Loss or suspension of license to practice medicine.

f. Loss of membership in Colorado Medical Society.

g. Non-payment of annual contribution.

5. There shall be no additional membership expense for members of the Trust other than the annual contribution mentioned above.

6. The Member further agrees to abide by all of the rules, regulations, policies and procedures established from time to time by the Trustees, notice of which shall be given to the Member in writing at the address contained herein.

IN WITNESS WHEREOF, this agreement is executed this

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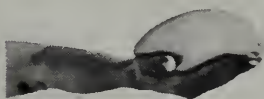
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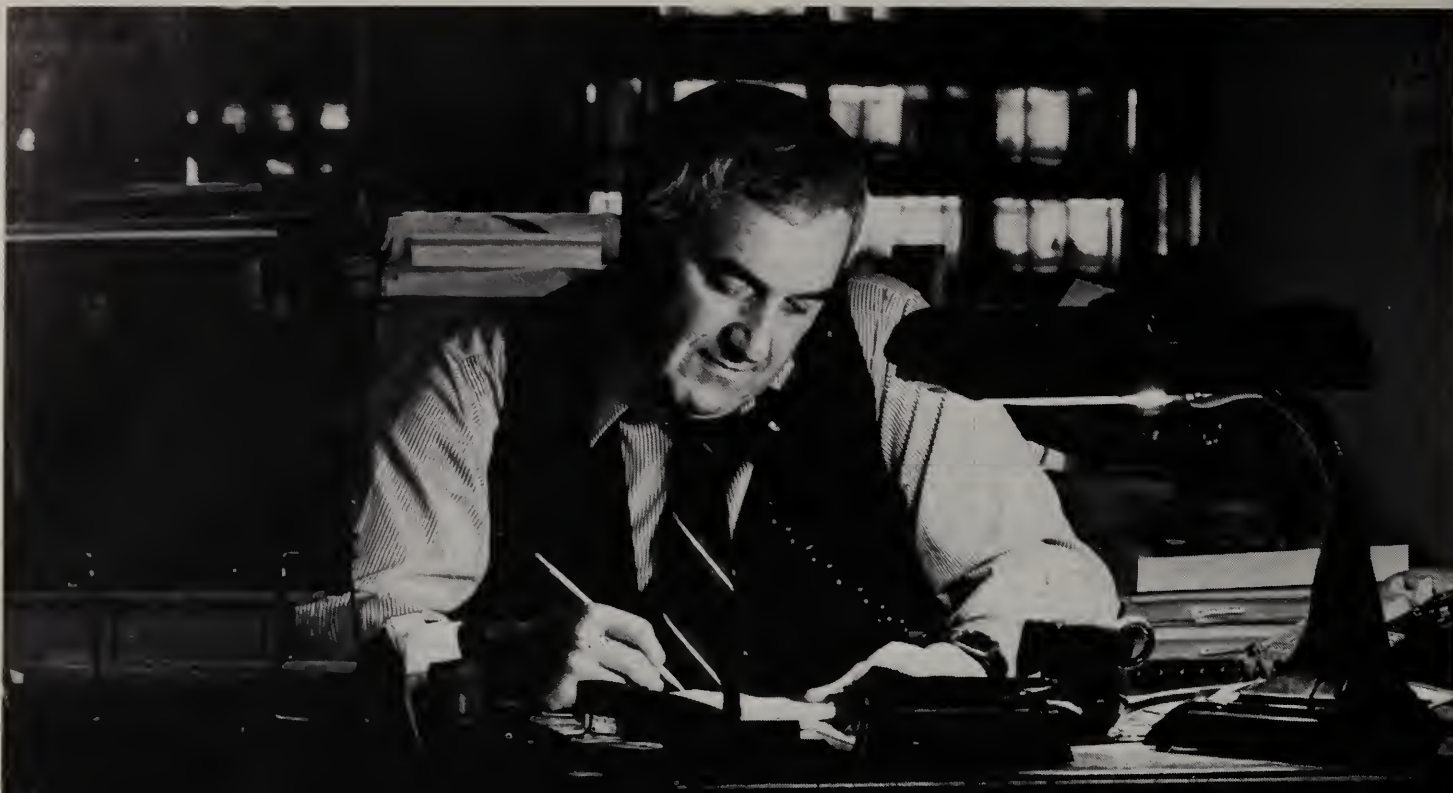
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